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ABSTRACT

This document reports the proceedings of a conference held in response to concerns about the nursing shortage and its implications for health care in the United States. Following a keynote address ("Nursing and Shortage: Part of the Problem or Part of the Solution?") by Dona Diers, the document is organized in five sections, with each section featuring two papers, two responses, and discussion. The paper titles and authors are "Current Data on Nurse Supply" (Evelyn Moses); "Update on the National Commission on Nursing Implementation Project" (Vivien DeBack); "Recruitment Strategies in Nursing Education" (Madeline Turkeltaub); "Recruitment Strategies in Nursing Education" (Kathleen G. Andreoli); "Recruitment Strategies in Long-Term Care" (Ethel Mitty); "Student Retention in Associate Degree Nursing Education" (Gerry Hansen); "Retention Strategies in Nursing Education" (Lucille Joel); "Nurse Retention: Long-Term and Short-Term Strategies for Improving Nurse Retention and Patient Satisfaction" (Edward J. Halloran); and "The Retention Process in a Community (Home) Health Nursing Agency" (Marilyn D. Harris). The responses to each paper and discussion summaries are included in the proceedings, along with recommendations, lists of participants and the agenda. (KC)

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Nursing Shortage:

Strategies for Nursing Practice and Education

Report of the National Invitational Workshop

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Health Resources and Services Administration
Bureau of Health Professionals
Division of Nursing

U.S. DEPARTMENT OF EDUCATION
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FOREWORD

A major activity of the Division of Nursing is to provide a central forum for discussion of complex issues facing the nursing profession. National invitational conferences are planned and convened for this purpose. When the Congress appropriated funds in mid-1987 to the Division of Nursing and the National Center for Nursing Research for studies related to nurse shortage issues, it was determined that a portion of the funds would be used to support national conferences. One would focus on nursing practice and education, and be sponsored by the Division, and one on nursing research sponsored by the Center.

Staff from both organizations met with a planning committee composed of six national leaders in nursing education and practice to develop agendas for the meetings. Both were held during the same week to accommodate some invitees' attendance at both meetings to provide additional continuity.

This document reports the proceedings of the conference held by the Division of Nursing. It is published with the expectation of stimulating further thought and discussion of the nurse shortage issue and its implications for the delivery of quality nursing care to the people of this country.

Jo Eleanor Elliott

Jo Eleanor Elliott
Director
Division of Nursing

ACKNOWLEDGMENTS

This report was prepared with the generous cooperation of the participants of the National Invitational Workshop on the Nursing Shortage: Strategies for Nursing Practice and Education, held February 22-24, 1988, in Washington, DC.

The contribution of these Planning Committee members is gratefully acknowledged: Dr. Elnora Daniel, Dean, School of Nursing, Hampton University; Ms. Jo Eleanor Elliott, Director, Division of Nursing, Bureau of Health Professions; Dr. Shirley Fondiller, Executive Director, Mid-Atlantic Regional Nurses Association; Dr. Gerry Hansen, Director, School of Allied Health Sciences, Weber State College; Ms. Marilyn Harris, Executive Director, Visiting Nurses Association; Dr. Mary Hill, Chief, Nursing Education Branch, Division of Nursing, Bureau of Health Professions; Ms. Lynda Joseph, Assistant Project Director, The Circle, Inc.; Ms. Melinda Mitchell, Associate Hospital Director and Director of Nursing, Stanford University Hospital Medical Center; Dr. Patricia Moritz, Chief, Nursing Systems Branch, National Center for Nursing Research, Bureau of Health Professions; and Dr. Lois S. Walker, Project Director, The Circle, Inc.

The contributions of Dr. Walker and Ms. Joseph are greatly appreciated. The helpful guidance of Dr. Hill, in her role as Federal Project Officer, ensured the success of all phases of the project. Dr. Moritz's collaborative work in planning workshop sessions and conference participation greatly added to the success of the workshop.

Editorial and production services were provided by Ms. Gayle Christman, Ms. Lynn Funkhauser, Ms. Sheila M. Jones, Mr. Rick Keir, Mr. Daniel McLaughlin, Ms. Renate Phillips, Ms. Tamara Shipp, and Mr. Daniel R. Tisch, all of The Circle, Inc.

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INTRODUCTION

The National Invitational Workshop on the Nursing Shortage: Strategies for Nursing Practice and Education was held February 22-24, 1988, in Washington, DC, under the auspices of the Division of Nursing in the Bureau of Health Professions of the Health Resources and Services Administration in the Department of Health and Human Services.

The Division of Nursing and the National Center for Nursing Research (NCNR) each planned a conference utilizing funds appropriated in 1987 in response to concerns about the nursing shortage and its implications for the Nation's health care. The NCNR conference was held on February 18 and 19.

The Division of Nursing workshop had as its objectives:

- Identify and explore issues of concern to nurses in practice and education related to the nursing shortage.
- Develop recommendations and strategies to assist nursing practice settings and educational institutions in recruiting and retaining nurses.
- Prepare action recommendations that have implications for the formation of national policy.

The shortage of nurses to provide care in hospitals became critical in 1986 when multiple changes in the health care system were taking place. New cost containment policies, increased use of biomedical technology, an aging population, and changes in consumer expectations had a great effect on health care and increased the demand for nurses. The increased demand for nurses took place at the same time the number of students in nursing schools was declining because of changing demographics of the college-aged population and increased career choices and options for women.

A planning committee of six national leaders in nursing practice and education set the workshop agenda during a daylong meeting with staff from the Division of Nursing and the NCNR in December 1987.

The planning committee structured the workshop to acknowledge the strong interdependence between nursing service and nursing education and to provide maximum opportunity for participant discussion. Four panels were assembled to explore the issues of recruitment and retention in nursing practice settings and educational institutions. Each panel was composed of representatives with both educational and practice perspectives to identify and discuss the commonalities between recruitment and retention issues. A 2-year review of the literature on the state of the nursing shortage in nursing practice and education was prepared as a background document.

Some 55 nurse administrators, nurse educators, and Federal Government officials met at the Vista International Hotel for the 3-day workshop. All participants attended the panel presentations after which they were assigned to small groups to develop action recommendations that have implications for the recruitment and retention of nurses in practice and education settings. At the concluding session, the workshop group leaders discussed and compiled the final recommendations.

The Executive Summary is presented first in this conference report, followed by the keynote address, the conference presentations, the recommendations, and the appendixes.

EXECUTIVE SUMMARY

This report presents an overview of the National Invitational Workshop on the Nursing Shortage: Strategies for Nursing Practice and Education held in Washington, DC, on February 22-24, 1988. The report contains information presented at the workshop in formal meetings, summaries of discussions following the formal presentations, and a set of recommendations compiled by the participants in the closing session.

The workshop was presented under the auspices of the Division of Nursing in the Bureau of Health Professions of the Health Resources and Services Administration in the Department of Health and Human Services in response to concerns about the nursing shortage and its implications for the Nation's health care. The National Center for Nursing Research collaborated in the planning and implementation of the workshop. Some 55 nurse administrators, nurse educators, and Federal Government officials met to prepare action recommendations to ensure an adequate supply of well-prepared nurses.

Because of the increasing interdependence between nursing practice and nursing education, the workshop was structured into panel presentations with representatives from nursing practice and education on each panel to address the relevant issues from each area's perspective. The three work groups preparing recommendations also featured a combination of representatives from the two groups.

The resulting discussions indicated that in nursing, recruitment and retention strategies are closely interrelated. Students who are attracted to a career in nursing seek admission to nursing programs and are retained in the programs when their learning experiences capitalize on the reality and excitement of the practice arena. Nurses in practice are recruited to work in health care settings that provide supportive environments and working conditions.

Concern was expressed repeatedly throughout the workshop that short-term, stopgap solutions alone would not solve the problems of nurse supply and demand. Measures such as increasing student stipends or providing higher entry-level salaries served as examples of solutions that have merit but are not sufficient to remedy the problem.

The general issue of increasing the nursing profession's influence over administrative decisions in practice settings was discussed in relation to recruitment and retention. One strategy to build nursing's influence was to identify specific nursing services in the budget, cost them out, and then bill the patient or insurer directly for them. Nurses could then point out specific evidence of their contribution to the revenue of the institution in arguing for greater influence. With greater influence would come a higher stature that would help in overcoming recruitment and retention problems.

The general issue of the need for an established career path in nursing was also discussed in relation to recruitment and retention. One suggestion was to place more emphasis on seniority through better compensation and other benefits. It was pointed out that a well-defined career ladder would ease turnover and afford higher incentives to potential nurses.

Another general issue was the need to improve the public's image of nursing. Several participants cited the public's negative view of nurses nurtured by television and other mass media. Discussion centered on the need for a well-financed long-term media campaign stressing the excitement and challenges of the profession. It was agreed that a better public opinion of nursing would aid a great deal in recruiting and retaining nurses.

The availability of data for research on nurse supply was also discussed extensively. In general, a need was seen for improved data gathering.

Recruitment strategies not only called for targeting the traditional pool of high school graduates but also minorities, men, and people changing careers in mid-life or later life. Strategies for schools included advertising with the campus newspaper and radio station, and promoting nursing in junior high and high schools through a speakers program and close work with counselors. One college of nursing offers an internship to high schoolers for college credit. Strategies for nursing practice included a strong advertising campaign, a campus affiliation program, and a speakers program to reach into the community as well as into the schools.

Retention strategies stressed the importance of close cooperation between nursing education and practice. A joint appointment policy for nurses and professors offers one example of this cooperation. Strategies for schools included a strong financial aid program, flexible class scheduling, and close relationships between students and professors. Approaches for practice settings included a fair salary structure, flexible scheduling, and a career development program.

The three work groups developed the following six recommendations. They are addressed more fully in the Recommendations section.

1. Establish a coordinated public relations campaign to positively change the image of nursing practice.

2. Provide support for demonstration projects that examine the long-term effects of innovative recruitment programs to increase the supply of nurses.

3. Provide support for demonstration projects designed to implement professional practice models for institutionally based nursing practice.

4. Establish mechanisms to provide direct payment to nurses for health care services provided by nurses.

5. Continue to provide direct support to nursing education programs that establish innovative curricula that relate directly to changes in health care and nursing delivery systems.

6. Provide support for the initial and continued preparation of nurse executives in hospitals and other practice settings.

NURSING AND SHORTAGES:
PART OF THE PROBLEM OR PART OF THE SOLUTION?

Paper Presented By: Donna Diers, R.N., M.S.N., F.A.A.N.
Yale University

If my assignment is to provoke some thinking about how nursing education and nursing service might address the nursing shortage issue, then perhaps the most provocative thing I can do is define the problem. And, where possible, define where the problem comes from. For unless we understand that, any solutions will be Band-Aids over a gaping wound.

I begin, then, with a redefinition. What we have here is not a shortage of nurses. The ratio of employed nurses to population is higher now than ever -- 533 full-time equivalent (FTE) positions per 100,000 (Prescott, 1987). There are more hospital nurses employed than ever -- over 90 per 100 beds (which is, of course, less than one FTE per shift per bed). As a proportion of total hospital personnel, registered nurses (RNs) now account for 58 percent (Aiken and Mullinix, 1987). A higher percentage of RNs are working full- or part-time -- nearly 80 percent. And further, the number of beds and the number of patient days is lower in 1987 than it was in 1982 (Aiken and Mullinix, 1987).

In 1983, the Institute of Medicine (IOM) declared that the supply of nurses was marginally adequate so the Federal role in supplying nurses could end, and that the responsibility should be turned over to the States. That was only 5 years ago. Only 4 years ago, the vacancy rate for hospital nurses was the lowest ever (Aiken, 1984).

I suggest that what we have here is not a shortage of nurses; it is a shortage of nursing. The problem is not supply; it is demand. And to document that, it is only necessary to show one set of figures (table 1).

These data are from the 35 general hospitals in Connecticut for the past 5 years (Thompson and Diers, 1988). They show that while there has been an overall decline in the number of patient days recorded on "routine care" floors, the number of patient days in special care has actually increased. Routine care days declined 23.1 percent over the period; special care days increased by 8.4 percent. Put that together with the American Hospital Association (AHA) data that have been used to define the current shortage. Those data suggest that the hardest jobs to fill are not the intensive care unit jobs; they are the general medical/surgical nursing positions. It is not that patients are sicker. Disease has not changed all that much, nor has invasive and heroic technology. What has changed is that there is a much narrower range of sickness to be cared for, and the range is all at the high end of the curve. Patients are simply not being

TABLE 1

ADULT MEDICAL SURGICAL SERVICES ROUTINE AND SPECIAL CARE DAYS
ALL CONNECTICUT GENERAL HOSPITALS

	Routine Days	Previous Year Percent Difference	Special Care Days	Previous Year Percent Difference
FY 1982[1]	2,477,557	+0.93%	173,324	+3.93%
FY 1983[2,3]	2,431,631	-1.85%	178,330	+2.89%
FY 1984[4]	2,273,474	-6.50%	183,637	+2.98%
FY 1985	2,067,421	-9.06%	183,892	+0.14%
FY 1986	1,880,413	-9.05%	183,544	-0.18%

[1] Tefra Passed September 1982
[2] Schweiker Report December 1982
[3] Prospective Payment Passed April 1983
[4] All But One Of Connecticut's Hospitals On Prospective Payment For Medicare Patients, First Day FY 1984

Source: Connecticut Hospital Association

admitted for rest cures any more, or diagnostic workups. Thus, the proportion of "sick days" in the hospital is higher, and so is the demand for nursing care. The statistics on which the IOM based its conclusions are simply painfully out of date, and the statistics did not anticipate what would happen with the prospective payment system. Indeed, any statistics that do not consider case mix, whether defined by diagnosis related group (DRG) or nursing intensity, will miss the point: the work has changed.

So, there is a perceived shortage in spite of the facts that there are fewer patients to care for, and that there are more nurses to do it. This is a shortage of nurs_ing_, not of nurs_es_.

A NURSING SHORTAGE

There is a point to this redefinition beside word play. To define the problem as a shortage of nurses is to suggest the easy solution: produce more. That is not even all that hard. Federal dollars did it before; they could do it again. Throw some money at student aid; throw some incentives in the form of capitation for increased class size -- it has all been done before with great success. Schools hungry for the dollars get creative about recruitment and publicity and pretty soon, we have fixed the warm body problem and we can go on to other things.

But the problem defined that way means it is just a warm body problem, fixed by more warm bodies. That definition converts nurses back into widgets, interchangeable parts in a massive machine, to mix a metaphor.

To redefine the problem as a shortage of nurs_ing_ opens up the possibility of examining instances, causes, and consequences differently, and perhaps coming to different solutions. The solution to the warm body problem is all too clear and basically uninteresting. The solution to the shortage of nurs_ing_, however, leads us to contemplate not only the shortage of nurses in hospitals, but the shortage in every other part of the health care system. There is a much wider range of variables to consider including barriers to practice, economic and social conditions, and, especially, the nature of the work.

NURSING TODAY

First, let us consider what nursing is. It is a great deal more than merely a, forgive the expression, _man_power issue, which is what the present construction of the problem as a shortage of nurs_es_ suggests.

Nursing is, and always has been, two things: the care of the sick (or the potentially sick) and the tending of the entire environment within which care happens. Nursing is not merely health promotion -- many people can do that, including lay persons. Granted, caring for the sick is a difficult business, and it is shared in complicated institutions with other professionals in a delicate balance of power. There will always be hospitals. There will always be mental hospitals, nursing homes, home care agencies, rehabilitation hospitals, and children's hospitals. And we are deluded if we think that the greener pastures of outpatient work or health promotion or ambulatory care (where, by the way, people are very sick) will be where nurses of the future will work. Nursing is care of the sick.

The reason for the existence of the modern organized health care system is to provide nursing care. If surgery could be done safely and economically on the kitchen table, and if people could survive it, it would be. If diagnosis and management of serious medical illness could be done in office practices, in 8.5-minute visits, it would be. If the chronically mentally ill could be taken care of at home, and protected from the world and from themselves, they would be. If the demented, the frail, the paralyzed, the very old could be cared for at home, they would be and it would be a whole lot cheaper -- because policy would not contemplate channeling the money to home care givers: they are supposed to want to do it anyhow.

The reason for the existence of the modern hospital, mental hospital, nursing home, and home care agency is to provide nursing care. Hospitalization is a call for nursing. The modern hospital, as a place of treatment rather than custodial care, owes its history to the discoveries of science -- antisepsis and later asepsis (Thompson, 1984) -- and the creation of the trained nurse. When surgeons learned that patients could survive their treatments if they were all placed together under controlled conditions of hygiene, light, air, and nutrition, it became necessary to have people there to tend to them. Fortunately, Florence Nightingale had started St. Thomas' School of Nursing in London (17 years before Lister started his hospital) and the modern hospital was born, catering not only to the orphans, pensioners, and the poor, but to those with means, too. As it later came to be a place which housed the resources physicians needed for diagnosis and treatment of disease, and where the watching, monitoring, and ministrations called nursing could be provided, nursing became not only central to the hospital, but the very reason for its being.

There is no such thing any more as "general" or "generalized" nursing. All nurses are specialists (Diers, 1985). That is simply the way the health care system is organized, and there is a reason for that. The amount of knowledge that it takes to deal with all of the possible things that can go wrong with all of the human body's systems, fluids, parts, or cells simply has to be broken into parts so that it can be apprehended. The organization of the health care system is not just a fiction of the politics of organized medicine -- it is the way the human body is organized or the way living is. The afflictions of children are different from those of adults, which are different for different ages of adults as well, and it simply makes intellectual sense to organize efficient health care delivery systems around the bodies of knowledge required.

When a nurse takes her or his first job, the process of specialization has to begin. Surely, specialization can change, but within a very short working time, nurses have to know a particular field in some depth, which means the depth of knowledge in another area is lost. That is okay -- with nearly two million nurses out there, there ought to be enough to go around, no? Well, no actually.

The hardest nursing job is the general medical/surgical position and it is not surprising that this position is the hardest to fill, according to the AHA data. It may be that this position lacks the glamour of the special care unit, or the emotional pull of pediatrics or psychiatry. But it may also be that the amount of knowledge needed to care for people in these kind of units is an enormous and unappreciated challenge.

In one typical university-affiliated hospital, data from two similar general medical units over a 3-month period showed 109 DRGs for about 500 patients. These are DRGs, not diagnoses, which would have numbered in the thousands (Flood and Diers, 1988). Not only do nurses have to learn (and relearn constantly) how to care for people with that many different things wrong with them, but they need to learn how to work with the 17 house staff, the 40 or so attending physicians, the four chaplains, the six social workers, and all the families as well. And, of course, the patients' particular sets of nursing needs probably come in easily 109 different categories, which do not match the DRG labels.

Surely intensive care is hard work -- after all, intensive care is intensive nursing care. But intensive care is more predictable than general medical/surgical nursing and is governed by tested protocols and procedures. What makes nursing difficult is the vague, risky problems -- the patients whose aneurysm might burst but has not yet, the uncontrolled hypertension, the potential bleeding, infection, confusion, or fall. In intensive care, there are a limited number of other professionals and they are by and large the same faces. The knowledge base in intensive care is much more firm: we know much more about the physiology and complications to be monitored and we know more about how to do it. No wonder experienced intensive care nurses say, "You could not pay me enough to do general medical/surgical work anymore."

We forget sometimes that one of the things which has produced the reality of nursing these days is that, slow as it has been, nursing has moved into the educational environment. Even diploma school curricula are no longer confined to repeated and routine practice of procedures, if they ever were. We are an educated society and even when fancy psychological theories, or even fancier immunological ones, are not explicitly studied in schools of nursing, they appear nearly daily in the newspapers and magazines we cannot avoid.

As nurses have become better educated, their capacity to find and understand problems in patient care has grown as well. Part of what makes for a shortage of nursing then (not nurses), is that there is more work to do because our own science and education has made it so. Before Dumas (1961), preoperative preparation was a shave and an enema. Before Elms (Elms and Leonard, 1966), admission to the hospital meant locking up the patient's valuables, introducing him or her to the roommates, pointing out the solarium, and charting vital signs. Before Peplau (1952), psychiatric nursing was either recreational therapy or muscle power. Before Ford (1982), outpatient nursing was measuring height, weight, and changing the paper on the examining table. Before Igoe (1980), school nurses were mainly good for getting you out of gym.

So there is a shortage of nursing because there is a lot more to do. Part of that is a function of changes in the use of hospitals stimulated by the prospective payment system, but already beginning to change before that (Thompson, 1985a). But the larger part is that the nature of the work itself has changed over time, without much attention or applause.

And, finally, the nature of nursing has changed, now with some consciousness, to encompass the second of nursing's social mandates: the tending of the entire environment within which care happens. Nurses are the ones who must see to it that everything else functions, that all departments do their jobs, and must fill in when they do not do them, especially in small community hospitals. How do we know this? Because we are the ones who get yelled at when it does not happen.

Aiken (1981) has pointed out that RNs are the most versatile of employees. We can do everything that aides and licensed practical nurses (LPNs) can do (and ward secretaries, interns, and other ancillaries as well). Whether institutions have indulged in downward or upward substitution, the effect on RNs is the same. If there is more ancillary help -- aides, technicians, and others -- nurses have to supervise them and that is work piled upon work. If there is a high proportion of RNs, there will also be fewer of them, and each one's job is bigger with no helpers.

The tending of the entire environment is something we have not particularly prepared or educated nurses for, except when we socialize our young into nursing and teach them how to get along with others. In particular, we have not paid enough attention to teaching nurses how the world operates, the laws of the jungle, how and why decisions are made the way they are, and especially, where the money and power are. And why.
But nursing is two things: the care of the sick and the tending of the entire environment within which that happens. The

"product" of the hospital is the episode of care; it is not the hours of nursing, the tests, x rays, meals served, or pounds of laundry changed and washed (Fetter and Freeman, 1986). A patient is discharged when the care is finished; the cure may never happen.

Thus, another thing that makes nursing very hard work is the constant feeling of incompetence, of being victimized without knowing what one has done to deserve it, of having no advocates, no place to turn, no help in making things happen. The imbalance between the authority, responsibility, and accountability of nursing is stunning and draining.

No wonder there is a shortage of nursing.

THE NEW SHORTAGE

But everyone seems to agree that this shortage is different, and most people attribute it to the diminished number of people either coming into the field or indicating an intent to do so in national surveys. This is the widget definition and while it applies to the future, it does not explain the shortage now. The new shortage is attributed to the lack of significant economic incentives, meaning an increased salary with a Bachelor of Science in Nursing (BSN) or even a decent salary, and the increasing tendency for college students to seek money over a chance to serve. Somehow, the working environment itself escapes attention.

Without disputing the truth of either of these attributions, there is a question here that needs answering: Whose problems are these? Or, in the words of the conflict resolution folks, who owns the problem?

There is an implicit message given out, particularly in the mass media, that these issues are problems with nursing, that somehow we caused them. Our negative public image is our own fault.

In a paper presented last summer to an invitational conference on the shortage, sponsored by Sigma Theta Tau, Aydelotte listed nine liabilities of the nursing profession.

The first four blame the victim:

1. A public image that augurs against recruitment of intelligent, ambitious, and motivated individuals.

2. A lack of an adequate number of nurses who can engage in self- and institutional-governance.

3. The inability of the profession to clearly articulate its economic value.
4. The failure to place high value on ... the staff nurse ... position (Aydellote, 1987, p. 15).

The list says we are ugly, timid, confused, impoverished, and elitist. I do not believe that.

Let us distinguish between two things: 1) the working conditions, demand, and turnover; 2) and recruitment. Turnover, not retention, is the problem in the profession; nurses are not leaving nursing in droves (Prescott, 1987). For there are different solutions depending upon how the problem is defined.

But, first, let us talk policy.

THE SHORTAGE AS A POLICY ISSUE

It is of interest that this conference and the one the National Center for Nursing Research (NCNR) sponsored last week are being held at the Federal level, and that in many States there are Governor's task forces or other bodies deliberating about the nursing shortage. That implies that there is something about a shortage of nurses that is an issue of public governmental policy interest.

A shortage of warm bodies, a shortage of nurses, is arguably a public policy issue. (So is a shortage of physicians, also addressed in earlier times as a public policy issue, but that is another story). It is not the government's business to worry about manpower except perhaps in the context of defense policy. But it may well be a matter of public policy to worry about a shortage of nurs*ing*, if access to care, the quality of care and the cost of care -- the policy issues -- are compromised. So let us redefine the problem.

Public policy in the United States regarding health care has not been exactly clear or coherent. But policy analysts, including Paul Starr (1982), have simplified things for us. Health care is a matter of public policy because of its relationship to economics. If people are not healthy, they do not work. If they do not work, they do not produce. Or, if they do not work, they do not have money to spend, which amounts to the same thing. Production is what makes the capitalist world go around, as the trade deficit panic has told us.

But, remember, the reason for existence of the modern hospital is to provide nursing care. When that care is not available, the capacity of the hospital to produce is compromised. Sure the hospital loses money, and so do physicians, but neither of those is a public policy issue. Access to care and the quality of care are compromised, so the cost/quality equation goes out of balance. *That* is the policy problem.

One study, mentioned earlier, of two similar general medical units examined the effects of short staffing (Flood and Diers, 1988). One unit was short of staff, using the hospital's own definitions, and the other was adequately staffed, again using the hospital's own definitions. For the most frequently occurring DRGs, average inlier length of stay on the short staffed unit was 1.28 days longer than on the other unit. When only the six most frequent DRGs were examined, the average length of stay was significantly longer on the short staffed unit for two of them. The hospital used a simple four-level measurement of nursing intensity, with level 1 being the lowest. The data show that nearly three-quarters of patient days on the short staffed unit were in category 3 or 4 (73.4 percent) while only a little over half (56 percent) of patient days on the adequately staffed unit were in the higher intensity catagories. The complications recorded were higher on the short staffed unit and were generally preventable -- generalized infections and urinary tract infections -- were the highest volume complications.

Another study says that when there is a shortage of nursing, nurses retreat from practicing the full scope of possible service and provide only minimal, safe care, in their own definition (Prescott, Dennis, Creasia and Bowen, 1985). Patients, or their insurers, still pay the same, however.

The cost of the nursing shortage cannot really be determined in the fullest sense. Lost days of work because treatment is delayed is surely a "cost," if not to Blue Cross. And lost income to physicians is surely a cost as well. The cost to hospitals of closing beds is serious since the fixed costs of the institution continue, even if salary costs do not. And hospitals do not decrease the number of administrators when the number of nurses goes down. The cost of keeping the institution open by using agency personnel is not only in the absolute dollars paid, which are considerably more than would be paid to the same number of employed staff (if they could be found) (Prescott, 1987), but also in the psychological cost to the employed nurses who earn less and work harder. I know of no study that has looked at a comparison of lost revenue from closed beds versus the incremental costs of raising salaries to staff the entire institution. Such a study ought to be done.

This same study I have been citing examined the costs of short staffing on these two medical units. The major cost -- revenue loss -- to the hospital occurs because of lengths of stay beyond the Federally-set point at which the price of care is set. The study concluded that the total differential net revenue loss to the hospital (annualized) comparing the short staffed unit with the other was $152,920, and this is only 1 unit in a hospital which has about 480 beds.

The shortage of nursing is, of course, not just in hospitals. A particularly flamboyant example of the expensiveness of a nursing shortage is upon us right now, and it also represents a failure of public policy.

The new law to regulate nursing homes has just been passed as part of the Budget Reconciliation Act. It is an unusual piece of legislation in a number of ways, not the least of which is in the

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detail of its prescriptions, unusual in law, more usual in regulations. The new law calls for serious attention to the patient's rights, including rights to information and informed consent, the right to have his or her own physician in attendance, and has the requirement for regular periodic assessment and care planning. According to the New York Times (Pear, 1988), the law is projected to cost an additional $832 million, primarily for compliance, to be shared by nursing homes, the Government and some patients. Buried in the law is the prescription for 24-hour licensed nurse coverage, and 8-hour per day, 7-day a week RN coverage, surely a very minimal requirement you would think would not have to legislated.

The Times report of the law notes that the nursing home industry has been subject to study and investigation for years, with continuing problems of quality (to say nothing of continuing scandals). The new law applies not only to nursing homes, but to home care, although the reporter acknowledges that home care has escaped the criticisms of nursing homes.

The reporter fails to make the important connection: nursing homes are staffed primarily by unlicensed personnel and it is no wonder, therefore, that there are problems of quality. It has been observed that it may be precisely this lack of professional personnel that makes the nursing home industry the most regulated of all sectors of health care. Home care, however, has been staffed and directed by RNs so it is not surprising that there are quality differences.

The requirement for more licensed personnel in nursing homes was initially resisted by the nursing home industry on the grounds that (a) it was too expensive, and (b) there were not any nurses to be had anyway (partly because the pay is so poor). The present law passed with a coalition of nursing home administrators on board. Why? The basic problem concerns the levels of reimbursement. Nursing homes have felt, with some justice, that the reimbursement system was tilted toward hospital care. This was one way to argue the reimbursement levels up. My colleagues in home care say that they have no problem at all with the new provision in the law -- they are already exceeding the minimum standards set. One might wonder whether it might not have been a better use of Federal funds to take the $832 million and throw it at upgrading nursing positions in nursing homes. There is little question that such a move would be cost-effective and effective in raising quality.

The policy issue was defined here as regulation; the perceived problem was control. The real policy problem -- the value problem -- is that the elderly or the chronically mentally ill (who comprise a large number of nursing home patients) have to be kept invisible. The new law amounts to punishment of nursing home administrations with a swift kick at Federal reimbursement rules rather than an acknowledgment of a concern for the elderly and sick which might suggest professional nursing care as a solution.

The shortage of nurs*ing* is a policy problem of another kind in the mental health system, especially the public system. In Connecticut, which may be a bit worse than some other States, there has long been a cap on admissions to State mental facilities because the staff was inadequate to handle admissions. So mentally ill persons, including substance abusers, have been backing up in community hospital emergency rooms (ERs) for years. The cost of their care in the ER is enormous, and the care itself is enormously trying for the nurses who work there. The mental health system devised an emergency and crisis intervention program to ease the problem, but it just created yet another fragment to an already uncoordinated mental illness treatment system. And the revolving door continues to revolve.

The reluctance of policy makers to consider the nature of the work in nursing homes or in mental hospitals leads to a definition of the problem that is simply incorrect. In neither case has the definition of the problem been framed so that innovative solutions can be sought; regulation has been the only answer, and regulation is always expensive. And in neither case (nor in the case of hospitals, for that matter) has the real nature of the institution been considered.

The reason for the existence of the modern hospital is to provide nursing care.

If nursing manpower is arguably a policy problem, then why are we here?

I suggest that the shortage of nursing -- not nurses -- does indeed come in part from the items Kitch Aydelotte listed, as well as some others, and that the part that is the policy problem is the extent to which nursing has been *prevented* from being part of the solution and instead has been labeled as part of the problem.

BARRIERS

There has been a long, systematic, and successful attempt to keep nurses away from the money. In a capitalist society, money is a way of keeping score -- the more you have or control, the more you are valued. The following are not the fault of nursing: the fact that nursing salaries are what they are, the fact that the range of salaries is so restricted that nurses reach the peak of the scale after about 7 years of working, and the existence of the restrictions on direct payment for services rendered. We are up against an intricately complex system of historical decision and rule, social power, and professional boundaries. But there is a simple way to think about it -- define the situation differently.

The reason for the existence of the modern hospital is to deliver nursing care. That being the case, the barriers in the way of nursing's capacity to do this become a policy problem. And when these barriers fall, and are advertised to do so, the problems with the public image of nursing as a recruitment problem will fall too.

A colleague told me that his answer to the question about why there is a nursing shortage is simple: "Who wants to join a powerless profession?" After I took my hands away from their grip on his throat, I thought about that.

All of the data about nurses leaving the field, or leaving a particular job for that matter, point to the same thing: lack of authority over one's own practice, lack of autonomy and professional recognition.

All of the data about what makes particular hospitals attractive places to work ("Magnets," AAN, 1983) and all of the data about job satisfaction say the same thing: authority over one's practice, autonomy, and professional recognition. Simply: the right to decide for oneself. That is the power we seek.

That power comes, however, not from argument, or position title, degrees, credentials, or professional association position papers. The power comes from having a desired resource, and these days, that resource is money.

Aydelotte says one of the problems is the nursing profession's inability to say how we contribute financially to institutions. But that is not our problem; we did not create it. There has been a deliberate attempt to keep nurses away from the money. It goes back to the 1930s when Blue Cross was negotiating contracts with hospitals (Thompson, 1987). At that time it was in the interest of the hospital, so it would make more money in those post-Depression days, to lump nursing's services in with the room and board costs in order to charge Blue Cross more. It is no more complicated than that, and not even political.

But time passed, and different forms of reimbursement sprang up. Government got into the act. There was a lot of money around and nobody particularly cared what anything cost. People forgot how to do cost accounting because nobody was paying any attention to the money anyhow. So, year after year, hospitals added increments to their overall budgets. There was some negotiation over the rates to be charged and everybody lost sight of the real relationship of cost to charge. And nursing was still buried along with brooms, breakfast, and the building mortgage. A nursing service administrator was "given" a budget that often included not only the nursing salaries and fringe benefits, but other things like small capital expenses -- intravenous poles -- and supplies and Xerox costs. The nursing budget often became the dumping ground for other expenses that the accountants did not know where to put. Later, when rate setting came in, the nursing budget was a convenient place to hide nonnursing expenses since everybody knows nurses are so expensive anyhow and there are so many of us and nobody looked inside the nursing dollars.

When people worried at all, it was about what nursing cost, since it was always such a big chunk of the hospital's budget, often the largest single chunk. Not many people were thinking about what nursing generated for the institution or, heaven knows, about the fact that if you believe that the reason for the existence of the modern hospital is to deliver nursing care, that nursing generates it all. There was hardly any thought about the fact that there was no way to manage the institution for quality or anything else because there was no way to link the services rendered to the services needed by those served. Hospitals were organized to deliver meals, laundry, x rays, visits, or whatever and great hordes of managers were needed to sit on top of those functional departments.

Head nurses were berated for approving overtime (money is a way of keeping score) but were given no credit when they stopped unnecessary tests or procedures, got the x-ray department to schedule the patient earlier rather than later, reduced duplicate tests, untangled bureaucratic nightmares, or found lost charts. Nursing was defined only as time (and thus dollars), not as service.

And because nursing was only a cost, a budget to be kept within, it had no power at the policy table. It only drained institutional resources; it did not make them.

In a conference last year on the nursing shortage, I said something of the same thing and then argued that the very first priority nursing must establish in order to fix the nursing shortage is to go for the money. I meant unbundling nursing from other costs and other ways of attributing costs, and relating nursing time directly to patient requirement and need, and to institutional need, too. Then, start billing patients or their insurers for those validated costs, and collect the money for the service, or bill other departments when we do their work (Diers, 1987). It is not a difficult idea, and it is not even difficult to do in these days of computers.

If you know the cost of something, you can attach a price. If you know the price, you can charge for it -- bill. If you bill, you can collect. If you collect, you have generated revenue. They who maketh the money get to decide how to spend it.

In other words, control of the resources generated by nursing gives nursing the control over our own practice, for we then have a way to negotiate using the same coin of the realm everybody else does.

The important point, however, is to be able to attach nursing services (and their cost) to patient requirements, which vary from patient to patient and day to day. This is basic to a variable billing system and cannot be replaced by global notions of nursing department budgets, which only allow a nurse manager to say how much it costs to treat a patient on the average (you just take the nursing budget and divide by patient days), but do not allow the manager to link costs to case mix -- to particular patients. Thus the only thing the manager can manage is the global budget, not the patient care itself, which is where the action really is.

To truly manage such a system means that institutions will have to decentralize because management of individual patient care requirements must be in the hands, ultimately, of those who deliver the service. Those who are closest to the expense need to manage -- not "control" -- it. When institutions decentralize, individual control over one's own practice is no longer an ideal; it is a reality. And we will have achieved the authority and professional credit we have said we wanted. It is possible, with the luck of idiosyncratically visionary management, to achieve such control and credit without having the money too, but it is a lot better with it. Money is a way of keeping score.

Money is something everybody understands and it gives us a way of talking about the work that is clear to the lay person, including the potential recruit. To coin a cliche, money is power, and having it means that nursing is no longer the "powerless profession" nobody would wish to join. Money keeps the score of nursing's role in health care delivery -- a measurable, quantitative, powerful index. Money managed in the service of others, committed to resources required by the enormous scope of the human problems we deal with, makes nursing visible and attractive even to those yuppie college kids who want to make money as a career goal.

Now, I said something like this at another meeting, (Diers, 1987) but I had to leave it a little early to catch a train. After I left the room, another participant in the conference, an Executive Vice-President and Dean of a medical center said:

> I think that Donna Diers' point to go for the money is the worst position to take ... That is not the image of nursing that should be projected to the American public as its central issue ... I am speaking ... to public policy and going for the money is the wrong public policy... (Stemmler, p. 1647).

Well, balderdash.

To be charitable, he may have thought I was suggesting going for more money, that is, increasing health care expenditures, and in a cost-conscious environment, that would be foolish. Actually, I was only arguing for nursing to have the credit -- an economic term -- for what we already do. Now, I would add an additional agenda.

There is a myth floating around that there is not enough reimbursement money coming out of Washington, and so States are being pressured to take more of the responsibility, primarily by increasing the rate ceilings. But, at the same time, the next phase of DRG-related work is commencing and people are beginning to use the DRG data system to probe more deeply into where the money is and where it goes altogether. We already know that medicare part B is the fastest growing part of the health financing system. Now, institutions are monitoring physician practice patterns for their use of ancillary services, as well as length of stay, and are producing reports showing how each physician stacks up against his or her colleague specialists treating the same DRGs. I have seen some of these data coming out of one state-of-the-art management project and they are stunning. There are millions of dollars tied up in ancillary services and extended lengths of stay -- dollars already being spent, which could be turned to other purposes, including nursing. To the extent that nursing is implicitly if not explicitly charged with tending the entire environment, we are in a position to contribute to the cost savings in these areas, and we should be able to claim some of those savings to enhance nursing's functions.

I submit that not only is "going for the money" the best possible way for nursing to rid ourselves of the "powerless" notion, but it is the best possible public policy. The policy issue here is quite simple: Money ought to buy something of value. Until we know what nursing costs and contributes, by patient, by day, by stay, we have no way of participating in decisions about whether the nursing budget is set at the right amount, or too low, or too high. We cannot be creative about using nursing resources. We cannot really develop the knowledge about what in nursing works or not. We cannot negotiate our resources, decide to spend now to pay off later, or make rational changes in staffing or other costs. And, most importantly, we cannot calculate the benefit of nursing's service because the value of nursing or any other service is always a tradeoff between cost and quality.

The operational barriers to attaching dollars to nursing service are already down. The public policy issue is that nursing may need the help of legislation or regulation to make it happen over the sloth or resistance of administrators or others. Now that the government has taken the position of being a "prudent buyer," we are in a position to help -- to be part of the solution, not part of the problem.

We may need the help of public policy to straighten out things in other parts of our field as well that are not really policy issues. Among the things that make nursing appear a powerless profession are the continuing well-advertised attempts to control our practices through regulation and other means. Third party reimbursement and prescriptive authority, for example, are not really public policy issues. But we may have to turn to legislation to make them happen since negotiation is unlikely to prevail with those who resist because of economic competition.

Public policy as law and legislation runs behind the clinical reality. Things have to change faster in the real world than the law or legislation can keep up with. Thus, nursing has often turned to public policy when issues were not necessarily matters of policy concern, to fix into place clinical realities. Bernardi v. Community Hospital Associates made hospitals liable for the acts of their employees and recognized that nurses are indeed employed by hospitals and liable for their own acts (Hogue, 1987, p. 44). This not very novel interpretation, however, brought nurses out of the employment relationship to physicians, which had created the respondeat superior ("captain of the ship") doctrine so politically abominable to nurses. Darling v. Charleston Community Hospital made hospitals liable also for the acts of physicians to whom practice privileges had been granted, and interfered with the conveniently casual relationship physicians had to institutions, which they treated like their workshop (Hogue, 1987, p. 80). Sermchief v. Gonzales brought modern nursing practice to public view, rejecting the claim that family planning nurse practitioners were practicing medicine without a license (Wolff, 1984).

Sometimes legislation has to be passed to clean up what cannot be cleaned up by negotiation. Wherever the educated talents of nurses are constrained by artificial barriers in law, regulation, interpretation of statutes, or common practice, there is a shortage of nursing.

A WIDER VIEW

Since the data upon which the allegation of the present nursing shortage is based came out of hospitals, it is assumed that the shortage is restricted to hospitals (Styles, 1987). But that is wrong.

I have already alluded to the shortage of nursing in nursing homes and in the public mental health system. There is also a shortage of nursing in specialist practice.

One of the dumb things that happened just before the prospective payment system went into effect in 1983 is that some hospitals, anticipating budgetary shortfalls, began to freeze nursing positions and then eliminate them. Some of the first to go were the clinical specialist positions, partly because administrators, including nurse managers, could never figure out what these people did, and partly because (once again) there was no way to cost out and evaluate their services. This was a dumb move for a number of reasons, but I will deal with only one of them.

The data on why nurses leave positions or leave the field list a number of "dissatisfiers" (Wandelt & Pierce, 1981). Salary is first, but number 3 is "lack of support on the part of hospital administrators." Number 4 is "insufficient opportunity for furthering professional education" and number seven is "lack of support on the part of nursing administration." Number 9 is "insufficient in-service education" and number 11 is "lack of competent support personnel."

Nurses want to get better at the work. We really do not consider ourselves robots putting the same piece of equipment together day after day after day. I said earlier that all nurses are specialists these days. And the most highly trained are the clinical nurse specialists -- nurses who have made a life work out of coronary care, oncology, pediatrics, psychiatry, or whatever. The role of the clinical specialist addresses all of the dissatisfiers listed. The clinical specialist runs interference, and because she or he has the power of knowledge, the clinical specialist is in a position to provide the managerial support nurses say they want and need. The clinical specialist is the built-in inservice person, especially when she or he collaborates in the care of particularly ill persons. Clinical specialists have access to libraries and secretaries, and they have to keep up with the literature and the changing science. They have *time*, which staff nurses do not, to read, write, or think something through, to serve on the interdisciplinary committees for Do Not Resuscitate (DNR) orders or Baby Doe regulations. Clinical specialists *are* the support personnel to the nursing staff -- not the ones to run errands and deliver things, but the ones to help the nursing staff with their work. They are not like the industrial line foreman whose role is controlling. They do not do staffing and discipline and punishment. The clinical specialist should be the clinical leader, and if that role is also combined with clinical management, so much the better.

The presence of clinical leadership makes the work of nursing more satisfying, the data say, and satisfied nurses stay. Where there is not that kind of clinical leadership, there is a shortage of nursing.

And again, this shortage shows up in nursing homes and in public mental health. Kane's work in nursing homes is convincing evidence of what can happen when gerontological nurse practitioners are allowed to work to the full scope of their practice (Kane, Jorgensen, Teteber, and Kuwahara, 1976). McBride's study of the clinical nurse specialist in a State hospital shows what can happen when that role is instituted (McBride et al., 1987).

Nurses want to continue to grow, to keep up with new knowledge, to be where the action is. In medicine, that means creating academic medical centers and geographic full-time attendings, and hospital practice privileges for clinical faculty of the medical school. The equivalent in nursing might be the clinical nurse specialist position, which attracts nurses to institutions and keeps them there.

Speaking of doctors...

When the Graduate Medical Education National Advisory Committee (GMENAC) report came out in 1980, there was another dumb interpretation that is connected to the nursing shortage. That report, as you know, predicted that there would be a serious oversupply of physicians in 1990, and the word went out that somehow that meant that at least some jobs for nurses were going to be scarce. Potential nurse practitioner students heard the word over and over: the doctors would take over the jobs and there would be no room for them.

Two recent studies suggest that the GMENAC predictions were off considerably, and that the problem is not nearly as serious as once thought (Clare, Spratly, Schwab, and Iglehart, 1987; Misek and Karnell, 1987). But the studies also show that the problem of oversupply of physicians continues to be serious in the high technology specialties; that is where the money is. Newly-minted doctors are not rushing to rural practice, family practice, general internal medicine, or pediatrics. Those practices do not offer the academic or financial rewards. In the meantime, as more and more things that used to be treated in hospitals are now dealt with in outpatient facilities, the need for primary care has only grown. As people are discharged earlier from hospitals, the need for skilled home care is there. As handicapped children have joined the educational mainstream, the need for skilled clinical services in schools is there. As more and more babies survive newborn intensive care with developmental disabilities and handicaps of various kinds, the need for experienced nursing to prepare these children for school has exploded. As the conditions of jails have been exposed, the need for more than just a once-a-week physician visit is there. As the terrible problem of AIDS has come to consciousness, the need for nurses has become obvious -- there is no cure to be had. As "managed care" has come to be a new reality, the notion of nursing in such systems, especially health maintenance organizations (HMOs), becomes essential. And, as outpatient surgery booms because there are not enough nurses to staff the inpatient surgical services -- well, need I go on? The notion (NHPF, 1987) that physicians will somehow turn into nurses to fill these gaps is just silly.

In all of these areas there is a real, demonstrable shortage of nursing. And it is compounded by restrictive laws and regulations with old-fashioned interpretations of what nurses are and do. Five years after Sermchief vs. Gonzales (1983) was decided, we still have State boards of nursing and attorneys general believing that listening to heart sounds is the practice of medicine, or that calling a red throat "pharyngitis" is illegal for nurses to do. Or that only physicians can recertify the need for nursing home care (when nurses have been figuring out how to get their services to medicare patients on home care for years (Mundinger, 1983)). Or that a physician must be physically present when a nurse-midwife delivers a patient in a hospital.

Or that regional anesthesia must be administered by an anesthesiologist, while a nurse anesthetist can only "top off" the spinal or the epidural.

What we are dealing with here, of course, is not safety. These restrictions on the practice of nursing are there for one and only one purpose: to protect the physician's billing opportunities. Surely that should not be a priority for public policy, much as some recent interpretations of law or regulation would make it seem so.

The present nursing shortage is only going to get worse, and not just because of the numbers-in-the-pipeline problem. Already, we know of the enormous growth in home care and nursing home care and unless policy dictates that the scandals of the nursing home industry infect other areas, more nurses will be called for. These will be specialist nurses -- nurses with particular learning in geriatrics, psychiatry, intensive care. I know of one home care agency in Connecticut that hires nothing but nurses with 5 years of intensive care experience; that is how sick patients are now at home.

The AIDS epidemic is going to get worse. The demands upon nurses will only grow and the demands will be both in and outside of the hospital. Again, specialists will be needed -- specialists in oncology, in infectious disease, and especially in mental health and substance abuse.

"Managed care" means nurse-managed care, whether the organization is technically a nursing center or not. "Case management" -- the magic solution to the problems of uncoordinated care is doomed to failure unless the case managers are skilled at whatever they are managing, which is, or ought, to be patient care; primary nursing has taught us that. Case management is too important to be turned into baby-sitting.

And there will be new jobs, specialist jobs. Every new high technology service that opens will have to have a senior nurse running it. A bone marrow transplant unit is my latest local example. Nurses like those kinds of jobs -- they stretch our learning. And the opportunity to participate in a new and exciting field as a colleague is very seductive. These new positions will take nurses away from general medical/surgical practice, which is where they are most needed. Discharge planning departments are entirely nursing and always will be; they will have to change from a dumping ground (for those nurses whom the institution is letting work off their retirement), to places of creative planning and community-connecting.

And there will be new academic opportunities as well. Schools of public health, of health management, of hospital administration, and even of medicine are already coming to realize how much they need the contribution of nurses to the teaching of their students and to the findings of their research.

And, funny thing, there is about to be a new shortage of physicians. The restriction on importing foreign medical graduates (FMGs) has already produced one anecdote; one policy-type suggested that nurses move into the perceived gaps in pathology, psychiatry, and pediatrics where FMGs used to go. He has not yet talked to nurses about this, and we may well wish to resist doing others' scut work.

The shortage is of nursing; the shortage of hospital nurses is just the tip of the iceberg. But at least it poked nursing onto the policy agenda. Now we have to stay there, and now we have to change the agenda from quantity to quality.

A WARNING

Under conditions of a shortage, the temptation is to make do, to fill in the gaps with overtime, to stop doing nonessential things. Immediately after World War II there was an immense nursing shortage, as hospitals were built with Hill-Burton funds, as the Veterans' Administration developed, and as the nurses in the military came home to raise families. It was also a time of technological and scientific advance, which increased the amount of work to be done. I do not think it is an accident that this period represents a very low point in nursing's professional development and in the development of our science and service. There was just too much to be done; education, research, and thinking disappeared first. We should not allow that to happen again.

This time around the perception of the nursing shortage may be different because what is happening is not just more overtime; it is the closing of beds. We are saying "no" and turning from Pollyanna into Lysistrata. It is very difficult to say no when the demands get too heavy because we create an ethical dilemma: Patients need care, so how can we refuse to be there to give it? What patients need, however, is good care, and patients are not well-served by a strung-out, burned-out staff of nurses. Again, the problem is easier to deal with if it is redefined. Our responsibility is to deliver good care. The administration's or hospital's responsibility is to provide the resources to do it; it is not our problem. Surely we cannot abandon patients and walk off the job precipitously. But we can make clear the kind of conditions under which we will continue to work, and if they are not met in a reasonable length of time, then actions must be taken to stop the flow of patients, even if that means canceling surgery, closing intensive care beds, closing the emergency room to walk-ins, or whatever. Saying no is clearly the better short-term solution and it gets nursing a certain amount of attention. It makes possible some negotiations we have not had the chance to do. It makes administrators and professional colleagues finally believe what Knaus, Draper, and their colleagues (Knaus, Draper, Wagner, and Zimmermann, 1986) have shown: that where nurses and physicians work as colleagues and where the authority of the head nurse to close beds is supported, mortality rates in intensive care drop. Surely such cooperation and its effects extends to other types of institutional care settings.

This is a time for creative grappling with the basic problems of control and power.

This leads to the question: In whose interest is it to have a nursing shortage? Organized medicine is already basking in the publicity that there are more college students intending to be physicians now than intending to be nurses. The response of the American Medical Association (AMA) to the nursing shortage is instructive (AMA, 1987). The AMA Board of Trustees has recommended:

1. Support all levels of nursing education, at least until the crisis in the supply of bedside care personnel is resolved.

2. Support government and private initiatives that would facilitate the recruitment and education of nurses to provide care at the bedside.

3. Support economic and professional incentives to attract and retain high-quality individuals to provide bedside nursing care.

4. Support hospital-based continuing education programs to promote the education of care givers who assist in the implementation of medical procedures in critical care units, operating rooms, emergency rooms, and medical/surgical areas.

5. Cooperate with other organizations concerned with acute and chronic hospital care to develop quality educational programs and methods of accreditation of programs to increase the availability of care givers at the bedside and to meet the medical needs of the public.

It does not take much of an intellectual leap to read into these proposals these serious concerns of organized medicine:

1. That its billing opportunities (especially in the high technology, high income specialties) not be interfered with;

2. That "care givers" at the bedside do not have to be nurses and that it might actually be better if they are not nurses for then they can be created, trained, and controlled by organized medicine, exactly as Physician Assistants (PAs) are;

3. That what the AMA wants is widgets at bedside, not the uppity nurses in specialist practice or in management who might ask troublesome questions.

We should resist the oh-so-logical notion that one way to fix the nursing shortage is to break the job down into definable tasks and then assign them out according to levels of personnel. Task discrimination is dangerous and only works downwards. If certain tasks are defined as do-able by lesser trained personnel, that will eventually mean that registered nurses should not do them, and that will turn the job of the RN into a manager of personnel. People become nurses because they want to nurse; writing the care plan and then turning over the care to others is not what is fun. Writing the care plan is a great pain, as a matter of fact. Breaking up the work of nursing in this way in order to compensate for a lack of manpower is a slippery slope upon which we should not set foot. Task discrimination is not slippery, but rather it is defining certain things as "not nursing." If it is not nursing, then we have no title to supervising it, assigning it, or taking the credit for it. We ought to retain title to all of nursing's work and not separate out by definition those things that can be done by others not even minimally trained in nursing. That category of work will only increase and so will the workers: they are cheaper. Even if others create new categories of personnel -- "obstetrical technicians" is one I heard recently -- we will still end up supervising them because we are the only ones who are there all the time to watch the work. We might as well own it.

We should argue for support staff to do the work that clearly is not patient care. This staff includes fetchers and carriers, secretaries, clinical medical librarians, clerks, housekeeping folks, and so on. We should expect that those who carry out these staff functions will assist the work of the institution, which is nursing. And if we have to do it, we ought to get the economic credit.

This leads us to another point that should at least be acknowledged even though it is really not our business to decide today. We had better pay attention to the boundaries and fences nursing is in the process of constructing between and among us. They only break nursing into smaller, weaker units when it could otherwise be a very powerful occupation. I refer particularly to the entry issue. We might take a lesson from medicine here. One way medicine has made itself into a sovereign profession (Starr, 1982) has been to claim all the turf for itself. Medicine scooped up pharmacology a long time ago; it has claimed administration by requiring physicians on boards, or AMA-approval of programs, or other things. It has claimed insurance as physicians dominated Blue Cross, controlled Blue Shield, and invented part B of medicare. It has sometimes even claimed nursing. Listen to the language of the Medical Practice Act in Michigan:

> "'Practice of medicine' means the diagnosis, treatment, prevention, cure, or relieving of human disease, ailment, defect, complaint, or other physical or mental condition, by attendance, advice, device, diagnostic test, or other means,

> or offering, undertaking, attempting to do, or holding oneself out as able to do, any of these acts." (Andrews, 1983, p. 21)

Nursing -- all of it from basic hygiene to the most complex clinical decision making -- belongs to us and we should not sell any of its parts to anybody else.

The perception that something is broken in nursing and has to be fixed by changing the standards for entry into the field raises these questions: Whose perception is it? Why cannot there be several ways to enter the field? The discrimination in levels of competence should be done in the clinical arena and not automatically on the basis of educational credentials. One of the ironies in nursing is that there are no reliable data about the differences between graduates of different kinds of educational programs. In fact, it embarrasses some that diploma graduates still tend to have the highest scores on the NCLEX examination even though it is intended to test the kind of nursing process thought exclusive to BSN education. One thing we simply do not know, and is not accounted for in these proposals, is who the diploma or associate degree graduates were before they were nurses. It has been estimated that perhaps 30 to 40 percent of associate degree graduates were college graduates before, and it is not surprising that they perform as well as new BSNs.

What is the problem here? The present multiple-entry system has been in place for some time and it is working. "If it ain't broke" -- and the data that the system is indeed broken are lacking -- "don't fix it," particularly if, in fixing it, we begin to impose artificial limitations on people's abilities to give human service. Licensure has only the most tenuous relationship to competence (Johnson, 1983). There ought to be ways in which people can enter the field and then progress in it, either through an educational or a clinical ladder, on the basis of ability and desire, not on artificial distinctions. The present obsession with entry seems only to alienate nurses from nurses, an odd stance to take just at a time when a coherent statement about nursing might be in order. Surely there should, and could, be differentiations between nurses. Those should be made in clinical institutions. There are only a few random attempts that are not well designed to differentiate on the basis of education. Otherwise, it is not being done and for a very good reason: It will not work. The clinical world just does not break up that way. In the same way, it also resisted the style of practice imposed by the "integrated curriculum" (Hipps, 1981). It also resisted confining nurse practitioners to the care of the "worried well" -- patients with minor acute or stabilized chronic illnesses. Mildred Montag (1983) has observed that associate degree education has turned out differently than planned, and that there are things in the Associate Degree in Nursing (ADN) curriculum now that were never anticipated when the preparation of the technical nurse was envisioned. But they are there, and they are working.

This needs to be fixed: the extent to which educational programming cuts off opportunities for continued growth and development, either in employing institutions which limit the upward mobility opportunities by defining steps by degrees, or in educational institutions which need to collect a lot of tuition and so require repeated, and wholly unnecessary, experiences.

Some labor economists have thrown another wet towel at us. Some argue that as long as "nursing" encompasses what they call the "most menial" as well as the most advanced activities, it will be hard to argue that salary ceilings should be pinned to the most advanced tasks. Rather, they say, the top salary will be fixed to the median level of task performance. This argument deals with the nurse as employee -- as widget -- and is as clinically ignorant as the integrated curriculum. Surely experience and knowledge ought to count, and the work of practice ought to be divided into chunks that reflect that. But the chunks are not likely to be tasks. They might not even be people. And we will drive ourselves mad trying to figure out which patients, by disease, service, or location, are the "hardest" to care for and thus ought to trigger that most compensation for the nurses. The hardest to care for may be the wandering Alzheimer's patient in a nursing home, now turned over to the least well-prepared, cheapest staff.

We are just now being able to find nursing as researchers begin to examine "nursing intensity" using real data and real quantitative methods. We have never known before, except intuitively, what kind of patients take the most nursing effort and what kind of effort they require. We are just beginning to discover the relationship, or lack of it, between nursing's resources and other resources. The possibilities of understanding nursing's work are mind-boggling.

As data systems evolve to analyze the nursing function by time, task, diagnosis, or indicator, we learn more about the work. For example, when DRGs are ranked according to nursing intensity, it is no surprise that among the most nursing-intensive patients are those with multiple trauma or head trauma. But it is a surprise to find that among the most nursing-intensive also are children, the elderly, especially those with stroke, and those for whom the treatment itself has caused dependency. We have found that depression and immobility are variables highly associated with nursing intensity (Talerico and Diers, in press). We have noted patterns of nursing intensity across days of stay, patterns which have implications for the number of and kind of staff, as well as implications for management of services at the unit level.

It is much too early to predict how this information will be useful to us because it is very new to us. The point to be made, however, is that now it is possible to even have information about nursing and how it works. We can use it not only to deal with shortages, but to make the best use of all of our resources, short or not. We are beginning, therefore, to move away from mere rhetoric to actual facts about how the health care system operates.

IMPLICATIONS

For the next 2 days you are going to have to come up with some recommendations, some aimed at the Division of Nursing. I am glad I get this place on the program and then go home because I am not at all sure where all of this analysis logically leads. Any paper about the nursing shortage runs out of steam when it comes to solutions.

Some nursing organization, or a combination of them, ought to immediately tackle the public image problem and simply hire the best possible firm of people who do image making for a living. If an advertising agency can kill new Coke in the service of selling old Pepsi, it can surely help us out. In fact, the Governor's Task Force in Maryland has suggested using advertising agencies. It also requested that the Governor use his influence to get advertising agencies to contribute the work pro bono. We should draw upon the data we have about potential nurses and about what we are told are the public perceptual barriers here. Nursing is primarily a female occupation. So? Advertise it that way to the feminists. Nursing is dangerous (you can get AIDS). Advertise it that way to the adventuresome. Nursing is hard work, hard physical and intellectual work. So? Advertise it that way to the smart ones. Expand our sight beyond the high school age group and tap the untapped resources: women whose children are old enough so that they can think of new options, hospital volunteers who might now wish a professional role, retired policemen and firemen. We might even give up our historic sexism and try to recruit men. That would certainly enlarge the pool.

But if we are to seriously recruit people into nursing, there has to be something there that will be satisfying, both in the educational programs and in the work environment.

The exciting and creative things in nursing these days are happening in practice, not in nursing education. That is a reversal of the order, caused in some part by the creative and innovative things that happened in nursing education 20 or so years ago. Thus the necessity to marry education and service seems obvious. But I think that at the present time service may help education more than the reverse. I am distressed when I hear that nursing service managers are approaching schools of nursing with peace offerings and white doves, as if the schools would solve their problems. That is again the widget definition and we must go beyond that.

We should take our guidance from as sure and clear an understanding of what nursing is these days as possible, from the work of the profession. Ask some staff nurses sometime what would make their working lives better and the answers will be rather simple: safe parking, tuition reimbursement, enough supplies and linens, shift differentials, a sensible shift rotation, and perhaps even participation in making scheduling decisions. Many of the solutions to improving the working environment are simply, or "complexly," managerial.

We do need good nurse managers. Not nurses with MBAs -- you can hire an accountant, financial manager, or marketing assistant. We need nurses who know the nature of the work; who know how to distinguish between responsibility, authority, and accountability; and who know how to argue effectively from data. We need nurses who know that the reason for the existence of the modern hospital is to deliver nursing care. Educational programs, including joint degree options with schools of business or health management, could be encouraged, with the requirement that there must be serious clinical specialty preparation as well. We need nurses who are prepared to analyze systems and policy. Knowing how the world operates is the ultimate empowerment. Educational efforts in this direction could be supported, but again, only when there is a clinical base.

Creative approaches to nursing education at any level can be successful if there is real understanding of the work of nursing. Undergraduate students are being prepared for the role we might understand as primary nurse. Why not involve selected primary nurses in the educational enterprise, with really truly faculty appointments and prerogatives? Primary nursing can be lonely; having a student around gives the nurse a chance to share the workload and the wisdom, and to have somebody to talk to as well. One could probably figure out a way to supplement the salaries of six or eight primary nurse faculty members for what it costs to hire one full-time assistant professor, and one could get a lot more mileage.

Ways to accelerate basic nursing education are not difficult to think of either. Surely students can be tested for competence instead of being asked to repeat past experience. College graduates or RNs from diploma and associate degree programs can be sped along faster than high school students. Upgrading RNs does not solve the quantity problem, but, taking the wider view of the quality issue, equipping nurses for leadership and change justifies the effort.

Although it is not really the responsibility of the Federal Government, especially through the programs of the Division of Nursing, to fix the working environment, there are times, and this may be one of them, when the carrot of the Federal dollar should be acknowledged. Under the excuse of Federal funding requirements, a lot of change can happen, especially if projects are set up as research and demonstration, or experimental. Schools of nursing may take advantage of this stimulus as well to attack some of the problems in nursing education, such as the inability of universities to count faculty practice as intellectual work, and the requirement of questionable curricula termed essential just because it has always been done this way. Part-time study can be supported if requirements for full-time enrollment in order to qualify for funds are adjusted. The temptation to create new nursing programs should be resisted, especially when the major result might turn out to be to sustain a faltering community college or small liberal arts college.

Special projects designed to bring the resources of educational and clinical institutions together can be supported. It should not be by just joint appointments and faculty practice arrangements, but also in other ways the resources of both can be shared. Schools of nursing have nurse-researchers. Can they be involved in studying turnover? quality assurance? developing information systems? Can they provide in-service education and staff development? Can they serve as systems consultants, helping the nurses grow in their understanding of the value of the work?

Clinical institutions have people who know how to do the work. Can they participate in the educational enterprise as faculty, as curriculum consultants, as partners?

Changes in the policy arena will continue to be the long-term solution to nursing shortage problems. Can we begin to work on that now with cleverly constructed experiences for nurses as legislative interns, consultants to policy makers, and members of policy and planning groups whose placements are orchestrated under special training projects?

A long time ago, at Duke University, there was a lovely project in which some newly-minted BSN graduates negotiated to have their very own hospital unit to staff and work in to the fullest scope of their training. Could such contracts for service or other institutionalized formats be devised now, as a way to demonstrate nursing at its best, and in its best management?

I am not sure that nursing services need more funds in the form of Federal dollars. Rather, I think nursing services need help in capturing the money that they already earn, and in negotiating to trim back funds now going in other directions. There is a lot of money in health service delivery; there is not, however, in nursing education. Whatever incremental funds might be used to target the nursing shortage ought to be carefully screened for the "widget factor" and not aimed simply at churning out more numbers from the same tired curricula into the same exhausted work environment.

Aiken and Mullinix (1987) have made five recommendations to deal with the nursing shortage. Three of them have to do with salary scales, shift differentials, and fringe benefits for experienced nurses. All three are problems internal to the service setting, solved by administrative activities that do not need to be supported by Federal funds or, at least, Division of Nursing funds. But perhaps there are ways the Health Care Financing

Administration (HCFA) could be encouraged to use its power to attack the nursing shortage creatively. There are two explicit suggestions, both of which have been made to HCFA without apparent success.

First, HCFA could mandate the collection of nursing resource data from all hospitals, at least for medicare patients. This would mean that it could require hospitals to break out nursing costs separately with two very simple additions to the Minimum Data Set: number of days in special care units, and number of days at each of, say, five levels of nursing intensity (Sovie, 1985; Thompson, 1985b). These two bits of information, combined with the information already collected, will expose nursing resources by DRG and allow reasoned consideration of proposals to use resources better. Without data, we just spin our wheels.

The second suggestion comes from Ed Halloran (1984). He has argued, effectively I think, that hospitals could and should treat the costs of nursing education as research and development (R and D). He defines these costs in service terms as portions of head nurse and clinician salaries. His own figures for University Hospitals of Cleveland show that, by the most generous calculation, nursing education costs were about 5 percent of the nursing service budget (or about 1.5 percent of the total hospital budget). Any company which produces anything invests between 6 percent and 8 percent of its resources in R and D, and many invest far more than that. For a hospital, nursing education is indeed R and D -- creating a work force. It can be argued that paying for medical education under medicare does not enjoy the same policy position. Regulations could be written to allow or even require hospitals to budget these kinds of R and D expenses.

Aiken and Mullinix (1987) argue that the work requirements of nurses should be restructured, and they specifically target the lack of support personnel and lack of computerization in nursing. Certainly computers could take over some of the routine memory functions nurses now carry out, and that would allow us to spend our resources more wisely. And certainly educational programs to make nurses computer literate could be supported. But what nurses really need is not simply the skills of the light pen and the screen menu. We need to know how to collect and use the data that can now be accumulated with ease with computers. We need to have nurses who are able to translate patterns of care or other information into management and clinical strategies. And, even before that, we need to have nurses who can contribute to the creation of information systems, so that our own variables do not get lost in the program. We should learn from the fact that it is only very recently that we have even unbundled nursing enough to find out how very valuable that capacity is. We should be preparing practicing nurses and nursing students to make use of this information now.

The fifth recommendation from this report calls for the development of more effective collaborative models of physicians and nurses. Surely there are opportunities here, but it would be hoped that such collaboration does not wait until the physicians are attendings. Why not start a course on nursing for medical students? Let us teach them all those technical things we end up teaching them anyhow, and let us sell cardiopulmonary resuscitation (CPR), too. As a matter of fact, what about special educational programs for non-clinicals in schools of business or public health or management, places that train the people who will eventually sit at the same management table as nurses? We could easily expose these students to what nursing is, teaching them something useful, like CPR, and begin to build a network of sympathizers.

Long-term solutions to the nursing shortage will depend also on having nurses in key places in the policy and public forums, including as journalists. Would it not be possible to support nurses seeking degrees or experiences in public policy, in journalism, in business and management as well as in nursing?

I am with Virginia Henderson in thinking that the way to change the public's image of nursing is to deliver good nursing care. But it is well-nigh impossible just now, in many places. We even know many of the solutions and it would not take much data collection or literature review to find out the rest. Many of the solutions are not appropriate targets for Federal activity and ought simply to be fixed at the local level.

The nursing shortage is code for something else: an intense examination and reformation of an obese and ineffective health care system. The United States spends more per capita and as a percent of the gross national product (GNP) than any other industrialized country in the world and even so it is for a questionable return on the investment. Our infant mortality places us about 17th in relation to the other developed countries. Our life expectancy is exceeded by Japan and Portugal, among others. Our death rates from trauma are higher than Australia, which has draconian penalties for speeding, running stop lights, and driving while drinking.

The "nursing shortage" is in danger of becoming a fad, a new obsession. Obsessing about numbers conceals the real problems of the work place, the money, and nursing's less than visible role in the minds of others. Nevertheless, the present crisis gives us an opportunity to discover what nursing really is and does. That visibility alone will be a recruitment device.

The nursing shortage is not our fault, and we must get over that notion first. Nursing is just fine; the working conditions are not. This shortage or any other future one will be attacked by solving the real problem, and releasing the talent and power of our numbers. We may actually not need more.

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OVERVIEW OF NURSE MANPOWER AND RELATED ISSUES

CURRENT DATA ON NURSE SUPPLY

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My intent at this time is to provide some overall background data on what we know about the number of nursing students and graduates and the number of registered nurses (RNs) in the supply.

Let us first look at the number of programs available to educate those who are preparing to enter nursing practice. As of October 15, 1986, there were 1,469 basic nursing education programs in the United States. The largest number of these were associate degree programs. While the 1986 total shows a decrease of 8 programs since 1984 when we reached the highest number in recent times, it also adds up to over 100 more programs than the number of programs 10 years ago. Major declines in the number of programs occurred among the diploma ones; both the associate degree and the baccalaureate showed increases in the last 10 years with associate degree programs leveling off recently and the baccalaureate programs continuing to increase.

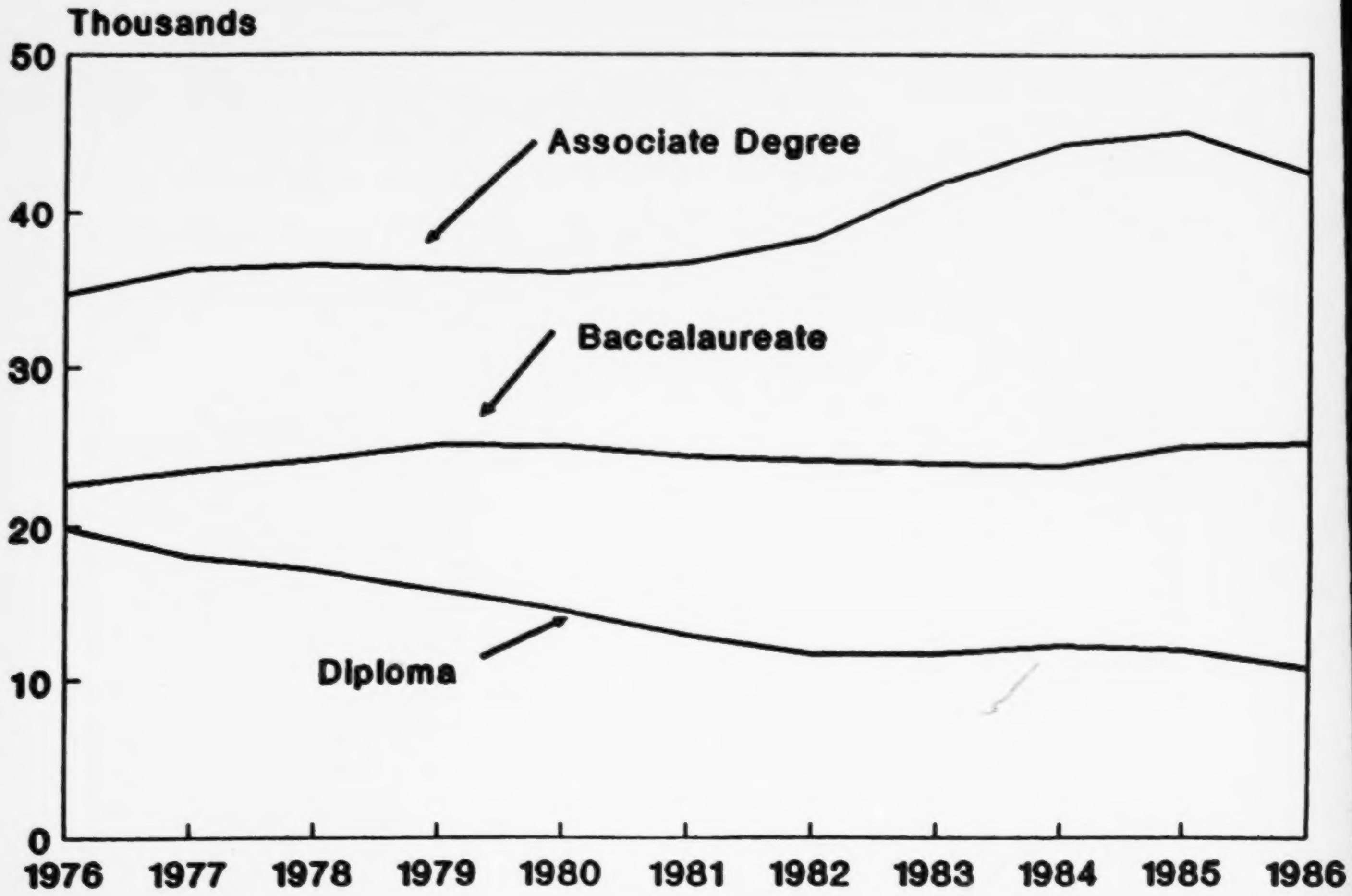
NUMBER OF GRADUATES

Basic nursing education programs graduated 77,027 individuals in the 1985-86 academic year (figure 1). More than half of these came from the associate degree programs. About one-third were from the baccalaureate programs and the remaining graduates (14 percent) were from diploma programs. The National League for Nursing has made a preliminary estimate of the number of graduates for the 1986-87 academic year of about 73,000, reflecting the enrollment declines noted in the last few years. In the 1985-86 and 1986-87 academic years, both the associate degree and the diploma programs declined while the baccalaureate programs increased slightly.

It might be helpful to examine the number of graduates over the last 10 years. The highest number of graduates of 82,075 was reached in the 1984-85 academic year. However, the number of graduates has not shown continual increases over the 10 years. After increasing during the early part of the period, the number decreased in 1979-80, reaching a low in 1980-81 about equivalent to the number estimated for 1986-87, before beginning to increase again. Except for some small increase in the number of graduates in 1983-84, diploma graduates showed consistent declines over the period; associate degree graduates generally increased until recently and the number of baccalaureate graduates did not show substantial changes over the time.

FIGURE 1

BASIC NURSING EDUCATION GRADUATES
Academic Years Ending 1976-1986



Source: NLN Annual Surveys.

The number of students enrolled in nursing baccalaureate programs has increased in the last 10-year period until it reached a high of almost 138,000 in the fall of 1983. In the early part of this period, however, about 8 out of 10 were generic baccalaureate students and the remaining ones were RNs initially prepared at the associate degree or diploma level. The proportion of students new to nursing to the total baccalaureate group declined to about 7 out of 10 in the late 1970s and early 1980s. In the fall of 1986, less than two-thirds of the baccalaureate students were new to nursing, with more than one-third of the baccalaureate student body composed of RN graduates of associate degree or diploma programs.

Although enrollments in master's degree programs have increased substantially during the last 10 years, the gains were made primarily by those who were part-time students. Seventy-two percent of the almost 20,000 master's degree students in the fall of 1986 were part-timers. Because of the increasing proportions of part-timers, graduations from year to year show little change despite the increased numbers of enrollees. In the 1985-86 academic year, the number of graduates totalled 5,248, virtually unchanged from the number in 1984-85.

ESTIMATED SUPPLY

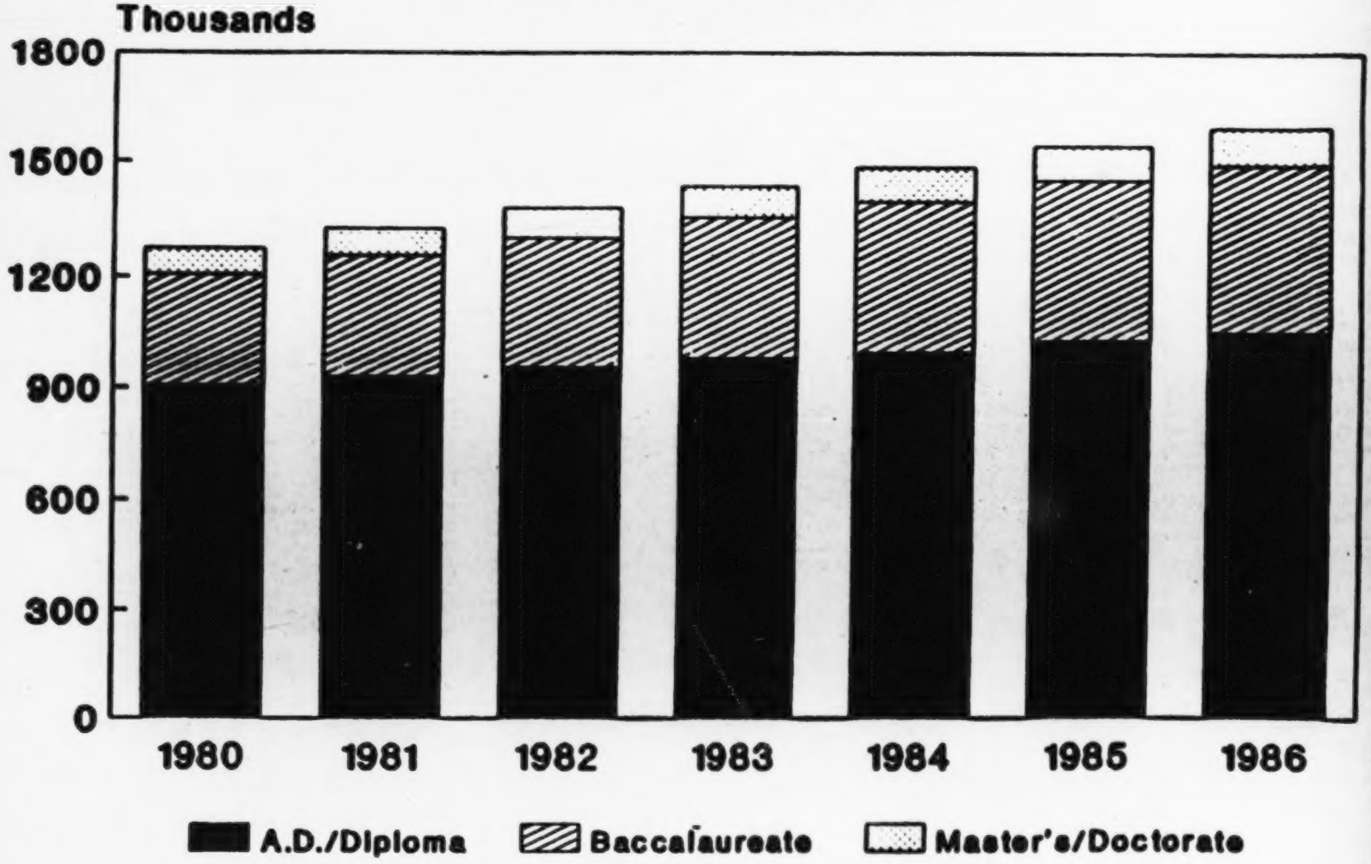
We estimate that as of December 31, 1986 there were 1,592,600 RNs in the active supply (figure 2). The highest educational preparation of almost two-thirds of these was an associate degree or diploma. While the number of those with baccalaureate and graduate degrees has grown at a much faster pace than the total active supply, the proportion of the total has changed only from about 29 percent in 1980 to 34 percent in 1986.

The number of RNs employed in nursing has increased over the years (figure 3). We anticipate a continual increase in this number over the next decade or so despite decreases in new graduates. New graduates have primarily been additions to the supply rather than replacements for those leaving. The number of new graduates has more than equaled the net loss resulting from those leaving for retirement or other reasons. Also, too, we have seen increasing proportions of those with licenses to practice being employed in nursing. In 1977, the first Sample Survey of Registered Nurses, found that about 70 percent of the 1.4 million RN population was employed in nursing. By 1984, the proportion employed in nursing was almost 79 percent. With this increase in the proportion of those employed in nursing came an increase in the proportion working on a part-time basis. In 1984, it was estimated that about 500,000, or 27 percent of those with licenses to practice, were employed in nursing on a part-time basis. These nurses were a third of the active supply at that time.

When looking toward the potential supply of RNs, there is a tendency to look first at the so-called inactive nurse. Indeed,

FIGURE 2

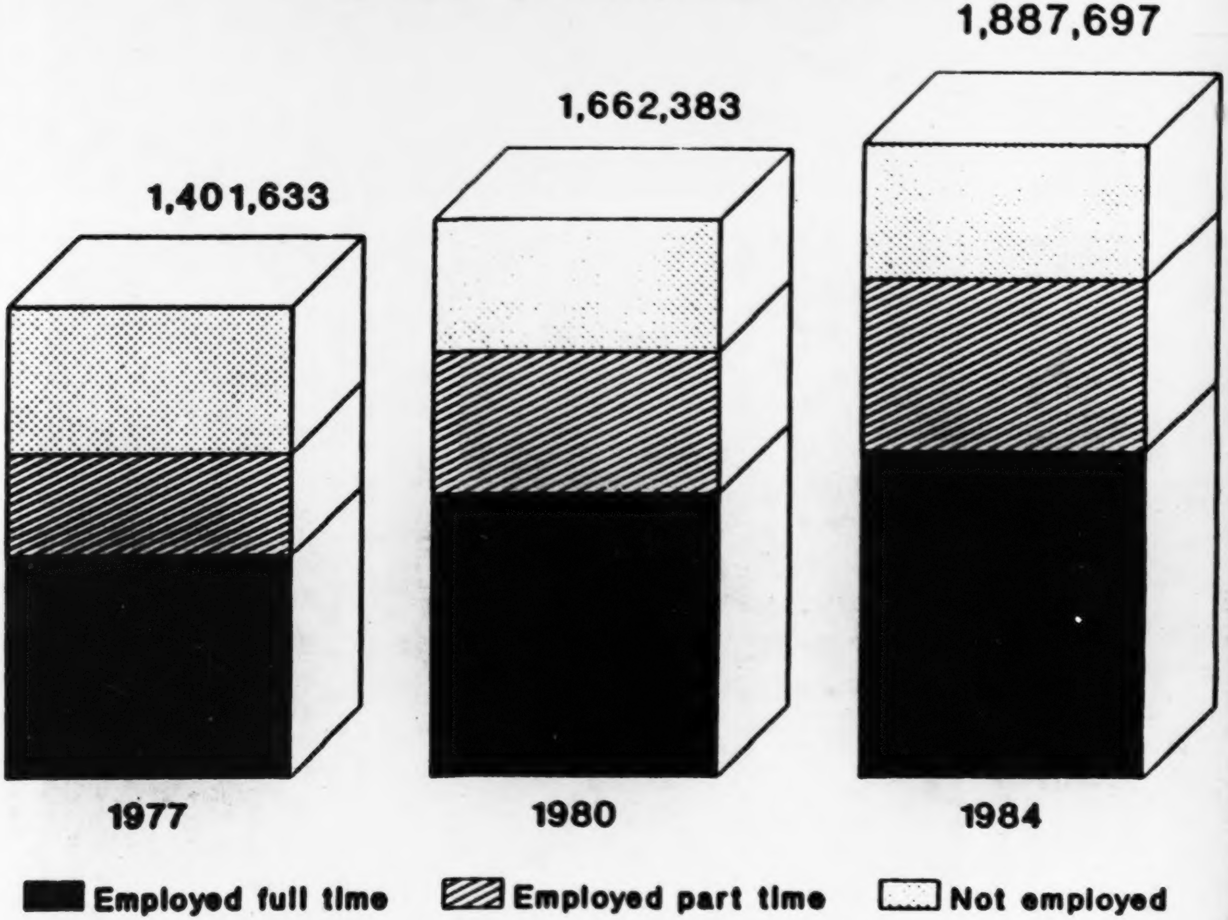
ESTIMATED SUPPLY OF REGISTERED NURSES
By Highest Educational Preparation
As of December 31, 1980-1986



Source: Division of Nursing Estimates.

FIGURE 3

REGISTERED NURSE POPULATION
by Nursing Employment Status



Source:DN, National Sample Surveys.

there were over 400,000 individuals with current licenses to practice as RNs who were not employed in nursing in 1984. Some 36,000 of these were actively seeking nursing employment at the time and about 87,000 were employed in positions outside of nursing and not seeking nursing employment. The bulk of them, however, were inactive.

INACTIVE NURSES

More than half of the inactive nurses in 1984 were at least 50 years old (figure 4). Over a third were 60 years old or older. Over 8 out of 10 of the 117,000 nurses under age 50 were married and had children at home; almost 60 percent of these had children under the age of 6.

RNs BY FIELD

The RN is found in all parts of the health care system (figure 5). However, the vast majority are working in the hospital setting. Sixty-eight percent of those employed in November 1984 were in hospitals. The remaining nurses were distributed in all the other areas of employment: nursing homes, community health, physicians' offices, health maintenance organizations (HMOs), nursing education, and other sites where health care is delivered, managed, and planned.

HOSPITAL EMPLOYMENT OF RNs

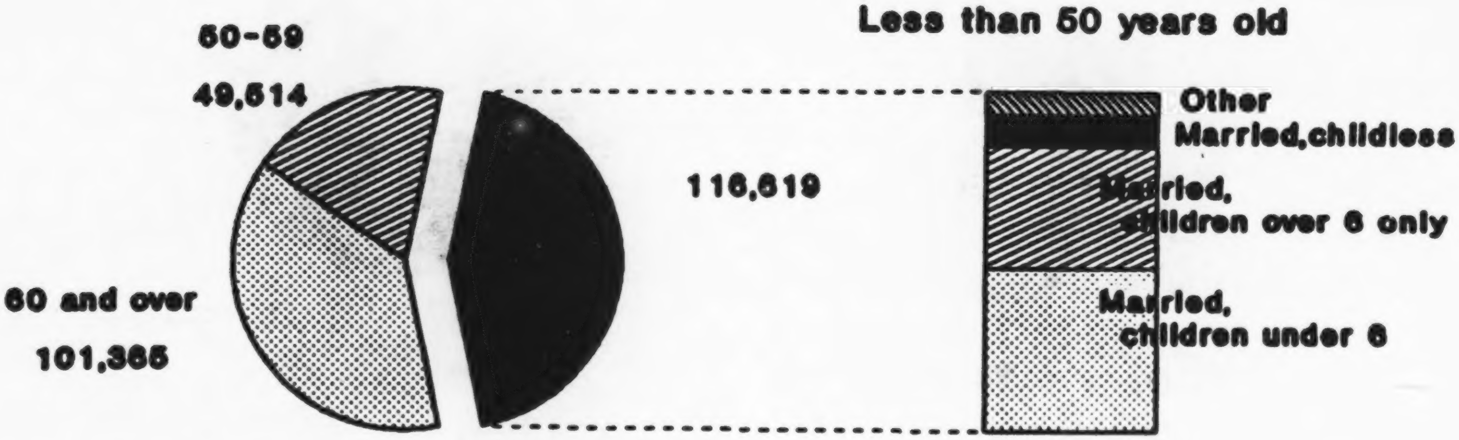
Since the hospital area is the predominant site of nursing practice and the one which has received the prime attention in discussions of the "nursing shortage," let us take a closer look at that area. Hospitals in the 1980s have increased their employment of RNs even though they may have decreased the employment of other personnel and decreased the number of patient days.

A review of some data from community hospitals will illustrate what has been happening. The community hospital, for the most part, is the one subject to the Prospective Payment System under Medicare, diagnosis related groups (DRGs), and cost containment measures on the part of other insurers. There was a substantial decrease in the number of inpatient days in the hospitals since 1982, about 18 percent. The number of outpatient visits, however, increased about 23 percent. Since 1982, when the DRG system was initiated, the average length of stay in hospitals has declined although in more recent years it seems to be leveling off. Patients who are 65 and over average about 3 days more in the hospital than do those under 65. About 43 percent of the patient days were for persons who were 65 years old or older. This percentage was fairly constant throughout the 1980s.

The increase in the employment of RNs in hospitals is most dramatically illustrated by two sets of numbers. In 1981 and 1986, community hospitals had the same number of nursing personnel on their payroll; the number of RNs, however, increased

FIGURE 4

DISTRIBUTION OF INACTIVE RNS
November 1984

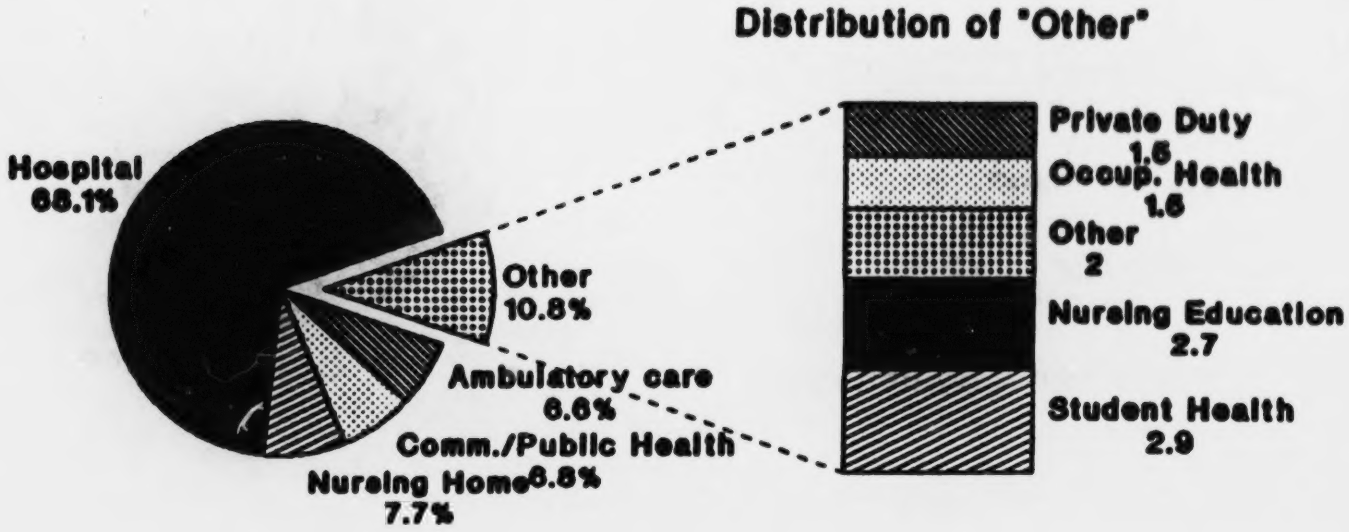


Source:DN,National Sample Survey.

FIGURE 5

FIELD OF EMPLOYMENT OF REGISTERED NURSES

Percent Distribution in November, 1984



Source:DN,National Sample Survey.

by over 100,000 and the number of both licensed practical nurses (LPNs) and aides showed substantial decreases. Since these numbers include full- and part-time workers, the conversion of these numbers into full-time equivalencies (FTEs) is a better measure of the amount of nursing time available.

The number of FTE-RNs on the community hospital payrolls in 1986 was 736,000, an increase of more than 100,000 over the 629,000 in 1981. These numbers suggest a substantial increase in the ratio of RNs per patient day. While this is undoubtedly the case, it is difficult to measure the true impact on the care of inpatients since these counts incorporate all nursing personnel employed by the hospital regardless of where they work and the type of position they fill, except those in nursing homes operated by the hospital. Hospitals have been diversifying their services; the impact of this on the employment of nurses needs to be examined more closely.

These increases in the numbers of RNs employed by the hospitals should also be measured against concerns about shortages. According to the American Hospital Association (AHA) report of its 1987 Hospital Nursing Personnel Survey, an overall shortage of staff RNs was reported as a problem by more than 50 percent of the community hospitals in the survey. The report states that, in contrast to 1983 when two-thirds of nursing service executives reported "no shortage," only 24 percent selected that option in the 1987 survey. AHA felt that there was too much missing data in the responses to compute an overall budgeted vacancy rate. However, its review of the rates for those hospitals for which they could be computed suggested that the budgeted vacancies were correlated to the executive's impressions of nursing shortages in the hospital.

NURSING HOME CARE

Care of the residents in nursing homes is an area which is generally looked toward as requiring improvements in the skill mix of nursing personnel. Nursing homes are the second largest employer of RNs. About 8 percent of the 1.5 million employed RNs in November 1984 were employed in the nursing home setting; over 40 percent of these were employed on a part-time basis. An examination of data from the studies made by the National Center for Health Statistics over the years suggest that, while there has been some improvement in the ratio of RNs to residents in nursing homes, in 1985 there were only 5.1 FTE-RNs per 100 beds. The 1985 study shows that nearly 40 percent of the 19,070 nursing homes in the United States had less than one-tenth of an hour, or 6 minutes, of RN time available per patient day with nearly 60 percent of these homes reporting no RNs at all. Unlike the data presented on hospital nursing, there are no data available on the number of budgeted vacancies for which the nursing homes are actively seeking RNs.

The home health area requires added nursing resources. In the November 1984 survey, about 101,400 RNs were employed in community/public health settings; about 40,000 of these were in nonhospital-based home health agencies. Little statistical survey data are available on home health which could be used to update this figure at this time. Not much data are available either on the number of home health visits made. However, data from the Health Care Financing Administration (HCFA) on medicare home health visits might shed some light on this area. There was about a five-fold increase in the number of medicare home health visits between 1974 and 1985. Of interest, though, is that between 1984 and 1985, the number declined slightly, perhaps because of changes in reimbursement for home health. To look at more recent trends, therefore, one would need data collected after 1985.

I hope that this very brief review of some of the data surrounding the issues you are here to discuss was helpful in placing into perspective the concerns you have heard expressed. While the focus of your discussions is not on data but on solutions, the data can be of help in identifying the problems for which the solutions are sought.

UPDATE ON THE NATIONAL COMMISSION ON NURSING IMPLEMENTATION PROJECT

Paper Presented By: Vivien DeBack, Ph.D., R.N.
National Commission on
Nursing Implementation Project

I am pleased to have the opportunity to discuss some of the work of the National Commission on Nursing Implementation Project (NCNIP). Most of you are familiar with the project's purpose, people, and process. For those who are not, I have written materials that describe outcomes and activities to date. I will concentrate on what we have learned over the past 2 years that has meaning for our deliberations on the nursing shortage. As you know NCNIP has been involved through a work group process and consensus-building activity at the board level in identifying future scenarios in health care. This is the agenda:

- discovering the consensus in nursing related to nurses' roles in a changing health care system;
- describing nursing's national direction that emerges from those data;
- developing strategies for action to ensure that nursing's future, as defined by the profession, does in fact happen.

The whole point of this process, indeed of the project itself, is so that nursing will plan the future in cooperation with other health care, business, payor, and consumer groups. One of the outcomes of such planning should be to reduce the possibility of recurrence of this shortage issue.

The national direction described by the NCNIP is based on nursing's decisions. Those decisions are to promote restructuring of the nursing education system, restructuring of the nursing delivery system, and creation and management of nursing information.

Just as consensus is building in nursing and we are planning for the future, we find ourselves faced with a nationwide crisis in a shortage of nurses and nursing which could divert us from using these decisions to continue planning and taking subsequent action. At NCNIP we believe planning and action based on these decisions are the solution to the nursing shortage. The national direction identified by the data was accepted by the governing board of the project. Following that acceptance, the board identified six objectives which are to be the focus of the project's implementation activities over the next 2 years. Somewhat short-handed, these objectives are:

1. promoting nurse-managed systems;

2. promoting differentiated practice, which means development of nursing roles intentionally based on the education of the nurse;
3. moving toward educating the new professional and technical nurse;
4. tracking the quality and cost of health care services provided by nurses;
5. assisting the public to understand the value of nursing research; and
6. translating the project objectives to various audiences.

Of course, we need a coordinated effort to accomplish it. At NCNIP, we believe that a coordinated effort requires different groups to do different things related to the same goals. For example, in the plan to track the transition of nursing education and delivery systems, we need:

- consistent data to help us gauge our progress in reaching our goals;
- other types of data beside that which is currently reported; and
- to link data for the restructuring of the education and practice systems.

For example, we need to know how we are changing the mix of the nurse's education, such as how many licensed practical nurses (LPNs) are currently enrolled in Associate Degree in Nursing (ADN) and Bachelor of Science in Nursing (BSN) programs. We need to know more about the jobs performed by nurses and how the jobs relate to educational preparation and credentialing.

We know that place of work does not give us information on type of nursing performed. Given how hospitals have diversified, for example, a nurse working for a hospital may be working in an ambulatory care setting, an intensive care unit (ICU), or in hospital-based home care.

The "nature of the work" and the nurse's educational background are critical to tracking change. In much the same way, we find that title alone does not give information on type of nursing performed or the educational preparation and credentialing required for the job. Just reporting data on basic education does not give us a handle on the nurses in baccalaureate, master's, or doctoral programs. When the education and experience of individuals change, practice changes. Therefore, in planning a restructured nursing delivery system, the data on numbers and types of nurses in the system are critical. These are challeng- ing data-collecting problems to be sure. We believe it is particularly significant that the Division of Nursing has called this meeting at this time because it is the agency we need to call upon to obtain some of these data. As we continue to look over strategies to recruit and retain nurses in the next day and a half, I would like us to consider adding this framework to our thinking: Let us figure out what data are needed on each issue we address. Let us identify who collects those data or who should collect them. Finally, let us determine what resources are needed to assure data collection.

An example of this is the fact that we need to track not only numbers of nurses, but types of nurses, on a continual and consistent basis. The Division of Nursing receives money to periodically survey, but we need data more frequently. Therefore, we may decide to encourage adding money to the reauthorization of the nurse education act so that the Division of Nursing can conduct the surveys to track transition. We are all here these 2 days to assist in the development of strategies to address the nursing shortage and to avoid a repeat of this shortage in the future. We simply cannot do that without the appropriate data.

At NCNIP, we can help link individuals and groups who have data with those who need it. In that way, the project can support the management of changes that represent long-term solutions to the issues of nursing supply and demand.

SUMMARY OF DISCUSSION AFTER OVERVIEW OF NURSE MANPOWER AND RELATED ISSUES PRESENTATIONS

The workshop participants agreed on the need for more data and information about nursing students and nurses in practice. Because more information is needed about the areas in which nurses practice, a new question has been added to the 1988 Federal survey that asks nurses working in patient care in hospitals to indicate the area of the hospital in which they are employed.

It was reported that there is a limited database about current nursing students but that it does seem to indicate that diploma and collegiate schools attract students who are similar to many of those who pursue higher education fairly soon after completing high school.

In contrast, associate degree programs are more likely to attract students whose average age at graduation is considerably higher than the diploma or baccalaureate degree graduates. More information is needed about the configuration of both generic and registered nurse (RN) students so that tracking can begin on when and how career decisions are made.

Action strategies planned for the National Commission on Nursing Implementation Project (NCNIP) implementation phase were identified:

1. Organize a major public relations campaign to improve the image of nursing.

2. Develop a major funding thrust to seek support from the various funding agencies in the country for the directions for nursing identified in the first phase of the project.

3. Establish a cooperative network at the regional, State, local, and institutional levels to look at strategies for actions to restructure systems in nursing education and nursing service, and create mechanisms to identify and track relevant data about these changes.

RECRUITMENT STRATEGIES IN NURSING EDUCATION

RECRUITMENT STRATEGIES IN NURSING EDUCATION

Paper Presented By: Madeline Turkeltaub, R.N., Ph.D.
Montgomery College

As you know, the health care delivery system is in a period of profound change caused by revolutions on many fronts -- technology expansion, insurance industry philosophy, Federal Government involvement, women's lib, economic trends in society, and even AIDS, and a host of others.

Many of these factors have really been around for years. When approaching the "crisis in nursing" today, I cannot help but think that today was yesterday's future. We need to go back to the future to plan for tomorrow.

A report of the Surgeon General's Consultant Group on Nursing stated the problems as follows:

- Not enough capable young people are being recruited to meet the demand.
- Too few college-bound students are entering nursing.
- The continuing lag in the social and economic status of nurses discourages people from entering the field and remaining active in it.
- Available nursing personnel are not being fully utilized for effective patient care -- including supervision and teaching as well as clinical care.

This report, Toward Quality in Nursing, was published in February, 1963! The solution then was money -- Federal funding to support new programs and traineeships. Nursing can no longer expect this kind of support. Just as we strive to be independent practitioners, so must we determine internal and independent means of solving what is viewed as a crisis (although cyclical and predictable) in nursing.

Decreased enrollments (and/or numbers of applicants) in nursing education programs historically have often been linked to job market demands. Basically, the cycle is shortage, salaries, advertising, benefits, more attractive shifts, and increased applicants in 18 months to 2 years.

In fact, nursing student enrollments have steadily increased with a peak occurring between 1975-83. The decline began in 1984. Although nursing service had experienced shortages in the past, this phenomenon was new to nursing education and occurred at a time when college enrollments in general were down. So what are we doing about it?

Marketing in higher education in general is a new concept. Marketing is best approached with an entrepreneurial attitude.

Nonprofit organizations (community colleges, State colleges and universities) have not marketed themselves as "businesses" in the past, although for-profit organizations have. It generally goes against our grain to call graduates our product -- but that is truly what they become.

Marketing strategies are now receiving more attention from higher education institutions, and we must adapt them for nursing. We need to make education for a nursing career and careers in nursing themselves tangible, visible, and visual products and build an aura about them. Communications should be created that relate to identified target audiences. This has a significant fiscal impact -- it costs money to look like a "class act" -- and it takes careful planning.

How much of the marketing budget can be used for nursing alone in an institution that has many other programs to consider? How committed is the institution to maintaining a nursing program?

Maybe you do not want to know the answers to some of these questions! Even mailings and purchasing mailing lists cost money and require a plan. High school students can generally be "reached" more readily as a group, but the more nebulous "returning students" become more of a challenge.

Do not overlook your internal audiences. It is important to discuss your mission and plans with faculty, staff, and current students. Identify your prenursing population and keep in touch with it.

Market studies can be conducted to follow up with those who did not come last year or the year before: Are they still interested? The Census Bureau makes demographic information available by ZIP code. The ZIP code distribution of applicants for the last several years should be available in an educational institution. The characteristics of the types of ZIP codes that were the best producers of applicants could then be determined. Those and other ZIP code areas with similar demographics would then be the most productive potential sources of students.

Marketing moguls warn us that some organizations improve their product's position by denigrating another organization's product. The professional image of nursing education can only be harmed by slandering or judging the competition. Marketing must accurately and honestly reflect the institution.

Faculty and staff must work together to create a collective impact. That is something many faculty members have not been involved with before and they need some encouragement.

What are we doing more specifically?

Visibility in a variety of settings is extremely important and can be accomplished in many ways. Some examples follow:

1. Speakers Bureau. Studies have shown that ideas related to career choice are formed in the third to sixth grades. Nursing faculty can provide speakers on health issues, the role of the nurse, body systems, and other topics. This can also extend into junior high school and high school classes.

2. Speakers Bureau for adult community. You never know when you might interest someone in nursing. This summer I participated in a course designed to teach elementary school teachers to teach science. They did not expect to see a nurse but all evidence gathered by evaluations indicated that they drew a relationship between a good course and a good nursing program. It was not our intent, but some students in the class itself are now interested in the nursing program. These were third to sixth grade teachers.

3. Cable TV interview. College cable television stations provide relatively cost-effective and efficient communications to viewers in a local target population. When shown within the college, these interviews enhance internal recruitment. College radio stations are generally easily accessible to those who are interested in providing an interview.

4. Follow up on requests for information from the media. Data on nursing admissions was requested from the Department of Institutional Research. The followup of this request resulted in an interview for the local newspaper related to career opportunities. Faculty members can write articles for press releases. This is both cost-effective and time-efficient, and increases visibility.

5. Hold seminars at your campus. Bring in guest speakers or sponsor a distinguished lecture series to increase the level of awareness of your program in the community.

6. Posters throughout your school can remind "undecided" students about the opportunity you provide.

7. When placing ads in papers and magazines do not forget to include publications at the home school. By the way, be sure to follow up by looking at ads, and listening to your radio spots. If errors are brought to the attention of the station, it will often offer several additional airings of the corrected spot.

Contact with counselors at all levels is important. Possibly nursing is suffering from a feminist backlash -- women who steer females away from traditional female professions but do not steer males toward traditionally female areas. We need to remind counselors of the satisfaction associated with nursing (as well as the increased salaries), whether for a male or female.

- Including counselors/career techs on your advisory committee increases their commitment to your program.

- Form a recruitment team which includes elementary to high school counselors.

- Invite counselors to walk through laboratory facilities.

- Seminars for high school graduates who have been out of school for 2 to 3 years.

- Create an early admission policy for outstanding students.

- Sponsor awards for top high school students for lab projects, volunteerism, and health-related activities.

- Invite one or two high school classes to get hands-on experience. For example, gloving videotape with return demonstration and evaluation.

- High school credit can be awarded for courses taken at college, e.g., an early placement program for high school students. It is important to work with counselors to get support for this concept.

Money -- a key word. Most of the activities mentioned cost relatively little for the return. We do know, from previous experience, that additional students are attracted when Federal dollars have been put into scholarships. We cannot expect much in the way of Federal support at this point, but we can seek funding and make scholarship information available.

You may have noticed increased solicitation from your alma mater. Even public institutions now have active fund raising efforts. Last year, a night was set aside at my institution for nursing students and faculty to call nursing alumni. Contributions for that night went directly into the Nursing Alumni Scholarship Fund.

Local savings and loan associations might negotiate special rates for nursing students. Hospital auxiliaries and similar organizations may sponsor scholarships.

Joint activities between service and education are among the most important efforts we can make.

To continue with the scholarship theme, affiliating hospitals may sponsor/support a student through outright scholarships (women's auxiliaries), subsidies, or stipends.

It is important to work with agencies that do not have a large budget for tuition reimbursement and would like to retain current employees -- nursing assistants and licensed practical nurses (LPNs). We have provided college counseling/advising services at the health care institution and have attempted to use joint appointment strategies. We also have applied money saved in faculty costs to a scholarship fund for students.

Since colleges cannot focus on one program among many, we need to assist each other to get the word out. Just as many colleges sponsor career days and invite nurse recruiters to attend, hospitals might do the same for local educational programs. Staff newsletters may be available for this purpose.

In Maryland, the Council of Deans and Directors and the Maryland Organization of Nurse Executives developed competency statements for graduates of associate degree, diploma, and baccalaureate nursing programs. This joint effort helped to correlate graduate competencies more realistically with entry-level expectations.

These two groups have now developed an ongoing joint committee which will continue to meet on a regular basis to develop a specific agenda for action.

Another group exists in Maryland that is made up of presidents of many of the nursing groups in the State (alumni associations, Maryland Nurses Association, National League for Nursing, Enterostomal therapists, and others). Although members may disagree on many issues, the group was able to focus its attention on the image of nursing. Working with the community service director of WBAL Television, a major station in Baltimore, the group was able to produce several public service announcements (PSAs) focusing on many faces of nursing -- not just the "glamour" of the emergency room. This community service director even volunteered his time -- know your influential contacts. The PSAs were reviewed for approval by the group, and were made available for distribution to other stations.

Refresher nursing courses, often offered through continuing education divisions at colleges, benefit both the individual and the hospital. Prepayment or return of payment by the hospital for the course to the newly "refreshed" nurse would serve as a recruitment tool. Employing agencies as well as schools should work together to provide incentives to encourage LPNs to become RNs, including scholarship help and flexible scheduling.

As many nursing programs have advisory committees that often include representatives from affiliating and employing agencies, so too may hospitals feel more free to invite faculty to join a hospital committee like one for recruitment and retention.

It is important to identify where our potential student population is coming from and where it will be going. We need to market both ends of the continuum.

Here are probably the most telling questions we can ask ourselves and probably everyone we know in nursing:

1. If you had to do it over again, would you still be a nurse?

2. Would you encourage your child to go into nursing?

The answers to these questions will provide valuable insight into the current crisis in nursing.

An increasing number of county, State, and Federal agencies are developing committees and task forces to investigate the nursing issue, although some do not even have nurses on them. The Maryland Hospital Association has created a Center for Nursing to coordinate communication about various efforts in the State in an attempt to concentrate, rather than dilute, the efforts to enhance recruitment in both the education and practice settings.

Creative marketing techniques can help, not as a panacea but as a new way of looking at nursing education. Some institutions may be in a crisis situation or nearing a crisis. If this happens, keep in mind the Chinese word for crisis -- it is made up of two characters. One means danger and the other means opportunity.

RECRUITMENT STRATEGIES IN NURSING EDUCATION

Paper Presented By: Kathleen G. Andreoli, D.S.N., F.A.A.N.
Rush University

Where have all the student nurses gone? If things remain as they are, this lament will be on the lips of nurse educators, patients, physicians, hospital administrators, and working nurses of the future. Indeed, there is every reason to worry. According to recent data -- data that continue to remind us that our job has only just begun -- on the American Association of Colleges of Nursing (AACN) member schools, the cumulative drop in generic baccalaureate enrollment since fall 1983, has been 21 percent.[1] Current data are more impressive. From fall 1986-87, the enrollment in these schools showed a 12.6 percent decline. Moreover, applications were down 24 percent in the same period. Although there is a 9 percent increase in enrollment of graduate students, this number does not, in general, reflect a new number of nurses in the work force.

By no means is this a short-term problem. According to a 1986 survey sponsored by Cooperative Institutional Research Program (CIRP) at the University of California, Los Angeles, and the American Council on Education (ACE), for the first time in history, women who intended to become doctors (25,000) outnumbered women who intended to become nurses (19,800) by more than 5,000.[2] Since nursing is 93 percent women, the changing career aspirations and work attitudes of college women have a critical impact on the supply and training of potential nurses. The decline in the popularity of nursing in universities is evident and the pool of college students is shrinking.

Projections indicate that by 1990 4-year institutions will award some 14,500 Bachelor of Science in Nursing (BSN) degrees, while medical schools will graduate almost 16,000. In a quality-assurance, cost-conscious society like ours, this scenario is unpalatable. A surplus of physicians is an expensive commodity in terms of education and practice costs. Moreover, the high quality, cost-effective care delivered by nurses will be at a minimum.

THE RUSH COLLEGE OF NURSING STORY

The enrollment trends for undergraduate and graduate education at Rush College of Nursing reflect the national picture. Thus, we have carefully analyzed our student recruitment program, retaining many of the existing programs and adding some new strategies. The program focuses on three populations: 1) students who wish to enter nursing, 2) nurses who wish to pursue an advanced degree, and 3) first- and second-career people who are searching for a new career choice.

Group 1: Aspiring Nursing Students

Once a person is committed to entering nursing, it is a matter of selling her or him on the best place to achieve this education. Thus, "selling" our college to these potential students is our goal. We deliver the message in writing, and verbally, that being educated at Rush College of Nursing provides the best return on the student's investment. The investment is high. A private college, Rush has an annual tuition of approximately $6,000 for undergraduate students and of $9,000 for graduate students. So, marketing the outstanding features of our school is essential for attracting students. Thus, we point out that Rush is one of a kind -- that is, a vertically integrated health care corporation composed of facilities offering tertiary care, secondary care, primary care, and research and health education programs for nurses, medical students, graduate students, and allied health students. We offer a comprehensive learning environment in the largest academic health center in the Midwest with 1,265 beds, including a 175-bed facility for the elderly, community hospitals, a home health service, a health maintenance organization (HMO), a preferred provider organization (PPO), individual practice association (IPA), and six occupational health centers.

In addition to the facilities, we operate under a model of unification of education and service. This means our faculty members practice what they profess. Eighty-five percent of the 1,450 hospital staff nurses are prepared at the baccalaureate level or higher and 96 percent of the patient care units (approximately 50) are managed by a Master's-prepared nurse unit leader. The clinical chairpersons in nursing are doctorally-prepared and of the 204 faculty members, 40 have doctoral degrees, and 51 are enrolled in doctoral programs. Nursing manages its practice via the matrix management model where nursing is parallel with medicine and administration in setting policy for health care delivery at Rush. Primary nursing is the foundation for care and the levels of practice provide recognition and reward for professional growth. A professional nursing staff organization sets nursing care standards and protects the quality of nursing's professional life at Rush. We pay the highest salaries for nurses in Chicago. Moreover, these salaries, commensurate with professional recognition, are in the top three ranges nationally ($23,920 to $42,893). With weekend and shift differentials, a highly skilled staff nurse could earn $48,000 annually. Finally, Rush offers an opportunity to students to work part-time in the hospital as nursing assistants. This work/study program is subsidized by the Federal Government, which pays 80 percent of the salaries. Currently, 175 students work. This addition to the hospital work force is appreciated.

We offer four academic programs in nursing: Bachelor of Science, Master of Science, Doctor of Nursing, and Doctor of Nursing Science. In a multi-entry/exit program, we have recently implemented the graduate entry option for registered nurses

(RNs), as well as individuals with degrees in other areas. Within the last month, 30 people have enrolled in our graduate entry option toward the ND degree. This advanced practitioner degree was initiated as a reflection of the advanced responsibilities of the clinical nurse and as a marketing strategy for attracting people into nursing.

Other recruitment initiatives that are aimed at the aspiring nursing student and prospective students include:

1. Campus visit programs twice a year. Eight hundred invitations are sent to prospective undergraduates inviting them to attend one of two "campus visit" days.

2. Nurse recruitment staff, student nurses, and staff nurses involvement in high school and college fairs; and health care presentations to high schools, community college fairs, college visitations, community-invited nursing seminars, and national collegiate fairs.

3. Campus affiliation program. Rush is affiliated with 16 colleges and we invite the schools to our campus. In turn, we send student recruitment representatives to the campuses. The health career advisor at each school is our contact person and supplies our office with student information. Successful students from these schools are automatically admitted to upper division courses here.

4. Active student advising/counseling walk-in, phone inquiry office with the ability to put together informal audits of transcripts and prepare a plan for completion of requirements. Each week our office sees about 10 to 15 prospective students.

5. Advertising in newspapers, special education issues, nursing journals, and other publications.

6. Rush Informer, a newsletter for prospective students with information not usually appearing in general recruitment brochures. Copies are sent to community colleges, our affiliate schools, and other colleges. It is also distributed to our inquiry pool.

7. College credit internship program. A one-week internship is required as part of a health careers course in local high schools. Students interested in nursing come to Rush.

The final recruitment strategy for influencing students to choose our college over others is our financial aid program. Clearly, our high tuition limits accessibility to all aspiring student nurses. Beside the work/study program, we offer a variety of other funding options. For example, each year we offer 20 nursing service scholarships. The scholarship terms are that Rush will provide 2 years of full tuition to a student nurse with the proviso that the nurse will work at our hospital for 2 years after graduation. Other forms of student aid include Illinois state scholarships, Pell grants, supplemental grants, university gift aid, Federal nursing loans, and guaranteed student loans.

Group 2: Nurses Pursuing Advanced Degrees

The unification model at Rush encourages nurses to continue their education. To facilitate this goal, generous prepaid tuition and tuition reimbursement programs are available to full-time and part-time nurses. If the course work is taken at Rush College of Nursing, the tuition is fully covered for full-time employees in a prepaid program. Seventy-five percent of the tuition is reimbursed for part-time nurses and nurses who wish to enroll in a program at another institution of higher education.

To encourage this group to enter the College of Nursing, we provide the multi-entry/exit program. This program offers the baccalaureate completion program for RNs. Area hospitals, community colleges, and student nurse associations are the target groups for marketing the completion option. Staff education coordinators schedule university visits particularly during Nurses' Week in May. This program builds upon the student's academic experience with opportunities to take challenge examinations in individually-selected courses. This is possible because we offer a flexible work schedule on the clinical units and a class schedule that supports part-time enrollment. The latter provides an incentive for nurses at other community hospitals to enter the post-RN programs at their level of choice. Campus visits for graduate students are sponsored and faculty from the graduate program specialty tracks attend and provide details.

A particularly popular graduate program for faculty in Illinois and neighboring states is our DNSc summer option. Required courses for the degree are taken over three successive summers. Cognate courses may be obtained at other graduate institutions and transferred to Rush. Clinical practicum credit is initiated at Rush during the summer and completed during the regular school year. The dissertation is completed following the third summer.

Assistance is available for students who want financial aid. Included are the professional nurse traineeships awarded to qualifying students as a stipend usually without consideration of financial need; guaranteed student loans for full- and half-time students based on demonstrated financial need; supplemental loans; the women's board scholarship; and alumni association scholarships based on need, grade point average, and academic references.

Group 3: People Seeking The Right Career Choice

Given the rapidly shrinking population entering undergraduate nursing programs across the country, the message is clear.

Unless there is a major turnaround in the near future, the nursing profession is on its way to extinction. The impact of such an event on the health care of the people of this country will be devastating. Every effort must be made to attract greater numbers of women and men (especially minorities) into nursing. With this mandate in mind, we have created a new position in the division, director of marketing.

This position has been filled by a marketing specialist with experience in creating and implementing marketing plans for major health facilities in Chicago. She has an impressive track record and educational background (MBA and BSN). The director of marketing is responsible for marketing programs dedicated to:

- retaining nurses on our hospital work force;
- recruiting nurses to our hospital work force;
- recruiting students to our college;
- recruiting target populations into the nursing profession;
- involving the alumni in marketing and fund raising; and
- developing the marketing plan for a major fund raising campaign.

Although the marketing director is involved in all aspects of recruiting, her major input is in the area of attracting target groups into the profession of nursing.

The groups identified in the marketing program are eighth graders, high school- and college-age people, men, minorities, parents/general population, and the current nurse work force. No recruitment program into nursing will be successful without the strong support of the profession itself. Regrettably, the willingness of the nursing profession to replenish itself is subject to question. In a recent poll of 8,023 nurses, 31 percent of the respondents would choose nursing if given the opportunity to choose their careers again. Alternatively, 35 percent might choose it and 33 percent would not. Moreover, 60 percent have not encouraged other people to enter nursing, while 38 percent have.[3] It is not unusual to find a new nursing student who will relate that she entered nursing in spite of nursing acquaintances discouraging her.

CURRENT NURSE WORK FORCE MARKETING

Thus, our marketing program began at home. To this end, we sponsored an essay contest. Prizes were awarded for the best composition on "Why I am proud to be a nurse." Not only did the contest promote positive thinking about nursing, it also gave us some original material for our marketing brochures.

We are also involved in a program of continuously communicating to our nurses how valued they are. We promote a "We're number one" cheer. This is validated by high salaries, attractive fringe benefits, administrative control of nursing practice, reinforcement and praise for innovations in care, and feedback of letters from grateful patients. Nurses must value themselves if they are to influence others to join them.

SCHOOL-AGE MARKET

The program directed at the school-age market includes:

1. Eighth grade market in 43 selected Chicago public schools. Chicago business and industry leaders, working in cooperation with the Chicago Board of Education, have created a "Careers for Youth" task force. One of the 16 clusters in the model program is health care. Nurses are invited as speakers to encourage students to stay in school and pursue a nursing career.

2. In-school Exploring Career Awareness (ISECA) program. This program for high school students is sponsored by the Boy Scouts of America. Nurses and other health professionals make presentations on health care at 10 Chicago high schools each year.

3. Community relations program for training selected high school students. Students are paid through a city-sponsored job program for their training (one summer). They then serve as volunteers on an assigned nursing unit at Rush (with a designated nurse preceptor) for 10 hours per week. They receive high school credit for the volunteer work.

4. Rush interim program. College students interested in pursuing health care careers can explore options in the health care environment of Rush. The program allows students to combine experiential learning with a didactic program covering such areas as hospital administration, dentistry, medicine, occupational and physical therapy, legal affairs, social work, medical technology, chaplaincy, and nursing.

MARKETING TO MEN

With only 7 percent of men in the national nursing work force, the next step is obvious. If the teaching profession and other primarily female professions (airline attendant, secretary, and telephone operator) can increase their proportion of men, then why not nursing? The greatest obstacle is the feminine connotation of the title, nurse. One assumption of our marketing plan is that if men market nursing, the chance of influencing a male decision is greater. We are enrolling our male nurses (76 men) to bring the recruitment program to all-male schools and clubs and to professions that are predominately male (policemen, paramedics, deacons). We are also engaging male physicians and hospital administrators to recruit male nurses.

MINORITY MARKETING PLAN

The CIRP study reported that the proportions of student nurses who are Black or Asian have increased significantly from 12 percent Black in 1980 to 17 percent in 1986, and from 1 percent Asian in 1980 to 3 percent in 1986.[2] These higher proportions, however, do not necessarily yield more minority nurses. Generally, minority students enter college with less academic preparation than their White peers and their attrition rate is higher. Therefore, our program concentrates on bringing qualified minority students into the school and supporting them in their studies. We have proposed a Rush-Chicago Board of Education Cooperative Plan.

After the first semester of the junior year in high school, minority students participating in the Principal's Scholars Program in selected public schools in Chicago would apply to the cooperative nursing program. These students would receive academic and counseling support, move with ease into an approved baccalaureate program in nursing, and secure scholarships/grants for the lower division of university work. Rush would offer summer employment each year between admission to the program and admission to the college (4 summers), nursing preceptors, academic counseling, and tuition scholarships for the prelicensure academic program.

PARENTS/GENERAL POPULATION MARKETING PROGRAM

Our marketing plan also aims at promoting positive thinking about nursing in the general population and by parents, since parents and public opinion often influence career choices. Here are some examples:

FUND RAISING PROGRAM

Our nursing division has recently entered into a corporate-sponsored fund raising campaign with the goal of raising $7 million to fund a chair in each clinical nursing department: medical, surgical, pediatric, obstetrical/gynecological, psychiatric, gerontological, and community health. The funding of these chairs by well-known people or businesses will raise the importance of the profession in the public's eye. The alumni association will also be actively involved in this fund raising program.

MEDIA MARKETING: PUBLIC SERVICE ANNOUNCEMENTS (PSAs)

We are also preparing a grant to underwrite the cost of producing demonstration PSAs. We plan to call on those who use nursing services -- physicians, hospital administrators, and the public -- to recruit for us through the PSAs. We will identify famous and familiar faces in all three groups. Nursing has been actively involved in colorful, creative, and interesting media recruitment advertising. Unfortunately, there has been minimal return on the investment. But, we believe that involving highly respected nonnurses in a television media campaign will increase our chances for public response. Let the experiment begin.

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RESPONSE TO RECRUITMENT STRATEGIES IN NURSING EDUCATION PANEL

Respondent: Anthony Disser, R.N.
United Health Services

Most hospitals are locally owned and operated. They strive to be responsive to the standards and expectations of the community they are serving. Therefore, nursing practice in hospitals is shaped, in part, by the expectations of the employing institution and its larger community. New graduates in their first nursing positions need help to adapt their view of nursing practice to the outcomes defined by the local community.

Nursing administrators must place more emphasis on understanding the data used by hospital administrators and the boards of directors to reach decisions about institutional policies and practices. Many hospitals today are learning that the key to retaining their market share and profitability is the ability to recruit and retain nursing staff. Nursing administrators can use this knowledge to demonstrate the value of nursing to the institution.

More collaboration between nursing education and practice is needed. Today's students should be helped to gain an appreciation of the costs of health care and nurses in practice should understand the financial aspects of running a hospital. Opportunities for teaching faculty to assume practice roles and nursing administrators to assume teaching roles should be developed to enhance the relevance and competence of each.

Solutions to today's nursing shortage should emphasize retention strategies for current nursing staff. Short-term strategies related to institutional governance, salary increases at the top end of the scale, and provision of support services for nonnursing tasks, should be considered. Long-range strategies are certainly important, but unfortunately they take a while to come to fruition.

RESPONSE TO RECRUITMENT STRATEGIES IN NURSING EDUCATION PANEL

Respondent: Vernice D. Ferguson, R.N., M.A., F.A.A.N., F.R.C.N.
The Veterans' Administration

The Veterans' Administration has long been interested in the recruitment and retention of nurses within our hospital system. We are taking steps to implement specific career and employment benefits that nurses have told us relate directly to their job satisfaction. Among these are career ladders that acknowledge clinical expertise and value direct patient care, flexible benefit packages that include provisions for child care, utilization of pay differentials for evening and night shift, tuition reimbursement, and professional sabbaticals.

There is a need for nursing to communicate the joy and vibrancy that many nurses experience in their practice. This terrific sense of job satisfaction has to be more effectively marketed if we want to attract new recruits to our profession.

Our students in nursing would profit from being taught by our most senior professors and experienced practitioners. Instead of assigning these professionals to teach graduate students, we need to involve them with beginning students who will benefit from their inspiration. In clinical settings we also need to use our senior nurses as role models for new graduates to aid them as they advance in the professional role.

SUMMARY OF DISCUSSION AFTER RECRUITMENT STRATEGIES IN NURSING EDUCATION PANEL

The two themes employed by the group were the need to project a positive image of nursing and the need for nurses to assert more control over the practice environment and its resources. The first emphasized enhancing recruitment and the second related to job satisfaction for nurses. In order to develop a positive image, the participants agreed that marketing strategies should communicate the job satisfaction and sense of vibrancy and joy in the profession. They also agreed on the need to enhance the image of nursing on all levels -- locally, statewide, and nationally.

Advantages and disadvantages of both lateral integration and downward substitution were noted in the discussion of enhancing nurses' control. The point was made that other disciplines have also been adversely affected by cost containment measures. The participants pointed out that increased control by nurses would lead to a work situation more attractive to new nurses. Nursing might be better served by attempting to seek compromises in salary negotiations rather than risk the elimination of full-time equivalencies (FTEs) associated with needed support services. This possible FTE elimination could result in decreased job satisfaction for nurses.

RECRUITMENT STRATEGIES IN NURSING PRACTICE

RECRUITMENT STRATEGIES FOR NURSING PRACTICE

Paper Presented By: Joyce C. Clifford, R.N., M.S.N., F.A.A.N.
Beth Israel Hospital
Boston, MA

Nursing practice in hospitals continues to absorb the largest number of professionals (68 percent) and, therefore, becomes an essential factor in resolving the overall issues related to recruitment. In 1973, at Beth Israel Hospital in Boston, we began to address a critical nurse shortage occurring then. Now our hospital is facing this current nurse shortage in a much more favorable condition than many, if not most, others because of the policies we started some 15 years ago. Very succinctly, Beth Israel Hospital continues to recruit well-prepared registered nurse (RN) professionals to deliver direct nursing care services to patients. We do not employ any temporary agency nurses, and we have not gone out of the country to recruit our nursing staff. We continue our standard procedure of recruiting nurses almost exclusively from that pool of approximately 30 percent who are prepared at the baccalaureate level. The hospital has not closed beds or reduced services because of an inability to recruit nurses. In fact, we continue to run a very high census and have a high case mix index. We have also experienced a decreased length of stay. We are, as many of you know, a major teaching, research hospital of Harvard Medical School and we are faced with all the trials, tribulations, joys, and complexities that that status brings.

Our Professional Practice Model remains very much intact and primary nursing continues to be our nursing care delivery system. We do not float nurses from one unit to another; we essentially have self-contained patient care units that are well integrated into the overall professional nursing service. And, with the salary program that has just become effective, all RNs are exempt, salaried staff. We have put a professional salary model in place to complement all other aspects of our practice model.

Why have we been able to continue in this way when others are having such difficulty? I can only speculate on the answer. And, my answer will sound pretty basic and perhaps even old-fashioned. We continue to attract nurses, I believe, because our system is designed to let the professional take care of patients. We recruit by marketing our philosophy and by operationalizing that philosophy, which has patient care and nursing practice as its central focus. For nearly 15 years we have examined and re-examined our practice model to ensure that it continues to provide a satisfactory environment for nurse professionals while also meeting the needs of patients and families. We are a value-driven practice system and these institutional values are derived from what we have learned over the years from our patients and our nurses. The literature speaks to these values as well and we have attempted to respond.

Continuity in patient care and services and accountability for those services are major components of our system. Nurse satisfaction with such a system continues to be one of our major recruiting advantages. Recruitment by reputation and word of mouth is a major asset for us. This reputation, by the way, usually includes the information that nurses work harder at Beth Israel than they do in many other practice systems, but that the rewards, particularly those coming from patient care and professional growth, outweigh how hard they work.

From an administrative viewpoint, it is also hard work. Our institution faces all the same evils of the current health care environment. It is faced with all the same financial difficulties (perhaps even more in the highly regulated State of Massachusetts) and it has the same kind of physician control issues as others have. But, institutionally, including at the board level, there is a strong commitment to good patient care. This commitment translates into a willingness to invest in and support nursing practice because of what nurses have demonstrated in patient care. Nursing practice is now highly valued by all as a major contributor to the quality of care received at Beth Israel Hospital.

In terms of specific recruitment strategies, Beth Israel Hospital does all the conventional things: career days, job fairs, visits to selected schools of nursing, open houses, and journal and newspaper advertising. But, once again, in each of these we have attempted to be consistent with our values, our philosophy. For example, one of the most sought after committees for nurses is our recruitment committee which was established many years ago at a time when we had much difficulty in convincing nurses to seriously consider working at the Beth Israel. Nurses at the hospital expressed dissatisfaction with the lack of recognition afforded them as professionals and they wanted to be more involved in decision making activities beyond the very important decision making authority that is integral to the primary nurse-patient relationship. We learned that as clinical nurses develop into experienced professionals they also want to contribute to the ongoing development of a professional department of nursing. Thus, participatory activities by staff are held in high esteem and their involvement is felt throughout the institution on many task forces, committees, and special projects.

The Nurse Recruitment Committee is one of the most popular of these activities. It is chaired by a clinical staff nurse and its membership is predominantly from the clinical staff. The two nonnurse recruiters employed in the Human Resource Department are members of this committee as is an education nurse specialist who works with the schools of nursing in facilitating clinical placements for students. This committee develops the annual recruitment program and budget and presents an annual evaluation of the outcome. It determines career days, open house schedules, job fairs, and recruitment themes. And committee members get to travel. They are involved in something that affects them directly so they are able to relay the message of the Beth Israel Hospital practice system with more credibility than those not as intimately involved. Decentralized decision making is again operationalized with this approach. Nurses on this committee, like those on others, have become vocal, influential professionals. They have earned the respect of their peers and their managers for the level of commitment they exhibit through their participation as well as for the successful results they achieve. Consequently, committee participation has become an important component of our Advancement and Recognition Program.

A clinical ladder, or Advancement and Recognition Program as we call ours, has become an area of great interest to applicants seeking information about our practice system. This interest correlates with what we know about today's young professionals. They are interested in the career opportunities, advancement, and compensation programs available to them and in what the system ("or corporation") is willing to do to invest in their future development. Although we believe that the practice system at the Beth Israel clearly attracts new applicants to us, we also know that the issues of work conditions, compensation, and career development are as equally important in attracting people into hospital nursing practice. Nurse managers at our hospital report that RNs do not focus their questions or discussion only on salary issues, but rather are very assertive in asking about our preceptor program. Will they be safely guided through their orientation? Experienced nurses express their concerns about staffing ratios, scheduling practices, and support systems, issues that ultimately relate to quality of care. Many nurses question the nurse manager directly, and sometimes harshly, about his or her philosophy about continuing education and willingness to provide support for the nurses' ongoing development.

Although we believe our system is very competitive in these areas, they are among the major issues that must be resolved in large-scale ways to make institutionally based nursing practice attractive for future generations of nurses and safe for the patients. Nurses do make a difference in the quality of patient care outcomes. But, if we expect to recruit successfully in the long run, there is an essential need for the health care system to promote the idea of direct care services provided by well-prepared nurse professionals and to establish a reward system for those services.

"Choose Nursing!" is the name of a program recently initiated by Beth Israel's Center for the Advancement of Nursing Practice. Its purpose is to provide factual information about nursing as a profession to young people beginning to make career choices. Guidance counselors, science teachers, and primary and secondary students need more than the distorted television portrayals of nurses as their yardstick for measuring the value and contributions of nurses to the health care system of this country. Lifelong career choices should be made from a reality base of facts and this program does that. Once again, in concert with our philosophy, the participants in this program have direct experience with patients and nurses. These experiences help them to appreciate more fully the complexity of nursing as well as the satisfaction to be gained by providing direct service to others. It is our belief that nursing should proudly promote its caring component along with the important aspects of intellectual stimulation and personal reward. By doing so, perhaps the future will entice more, rather than fewer, people to "Choose Nursing!" as their career goal.

RECRUITMENT STRATEGIES IN LONG-TERM CARE

Paper Presented By: Ethel L. Mitty, Ed.D., R.N.
Jewish Institute for Geriatric Care

In the past, institutional and community-based long-term care (LTC) had enjoyed some immunity from the nursing shortage. However, over the past 2 years, the pool of licensed practical nurses (LPNs) has not just constricted, but the quality of those in the pool has diminished to a frightening degree.

Nursing assistants make up 70 percent of a long-term facility's nursing staff. Of the remainder, LPNs make up between 15 to 20 percent and registered nurses (RNs) make up between 10 to 15 percent. It goes without saying that the few RN positions needed are increasingly vacant or filled with the remaining LPNs. This is particularly alarming for those nursing homes where high technology does not simply characterize patients' nursing needs, but drives the reimbursement system and fiscal solvency of the institution.

Regardless of the bed-size or ownership of the voluntary or proprietary nursing home there are three issues in recruitment which may be unique to LTC:

1. New graduates tend not to be hired: issue of skill base, unit management, paraprofessional management, continuing education needs.

2. LPNs do the same "work" as RNs: budget impact, issue of domain of "professional" practice.

3. Experienced nursing home nurses get no credit for their nursing home background when they seek work in the hospital sector.

ECONOMIC AND GENERAL WELFARE ISSUES

Regardless of bed-size or ownership, the salary offered by LTC facilities tends to mirror local rates. Historically, proprietary facilities paid less but this disparity is fast disappearing. In some locales, the LPN rates vary widely and increase the competition for LPNs.

In general, the voluntary nursing homes, like hospitals, are offering differentials of similar amounts for swing shifts, baccalaureate and master's degrees, and experience. Most proprietary facilities provide little or no degree differential and do not provide tuition reimbursement, as do the voluntaries. Every other weekend off is as commonplace as are the equal number of vacation days, holidays, and sick days. A well-touted feature of many nursing homes is that unused sick days are paid at the end of the calendar year. The psychological effects of this, not to mention the money, are obvious.

Many nursing homes capitalize in their ads and brochures on the fact that there is no mandatory overtime or shift rotation. This has been quite effective in competition with local hospitals, as has, in a perverse way, the fact that most nursing homes do not have patients with AIDS, a fact that is not advertised. We are beginning to be asked about this quite frequently by hospital nurses who want out of hospital nursing and caring for the AIDS patient.

In-house bounty hunters were marginally successful until about 2 years ago; the going rate was $500 to $700, payable in two installments, the first after 6 months of employment and the second after 1 year. The feeling pervades that this is no longer fruitful. The only other source of nurses has been the agency nurse who decides to join the staff after a respectable hiatus between agency and facility.

FLEXITIME AND THE "ASSIGNMENT" SYSTEM

Although a few nursing homes have flexitime, most have found that this system does not allow the proper levels of staffing. An underlying concern in using staff for a 10- or 12-hour shift is the quality of compassion and competence. Because the family is often as much a patient as the identified patient, the nurse cannot hide behind the tasks of nursing in settings which are characterized by the "continuity" of care. However, many nursing homes are using nurses for 4-hour shifts during peak care hours.

In the interview phase of recruitment, considerable time is usually spent on the description of the nurse as a "leader" of the interdisciplinary team. Although the leadership title may vary (e.g., head nurse, charge nurse, patient care coordinator) and this person might be an RN or LPN, it is unquestionably true that the nurse is the key figure on the scene. In the vast majority of the 23,000 nursing homes in this country -- most of which have fewer than 200 beds -- a physician will only be present for 2 hours a day at most. The nurse who enjoys physical assessment and diagnosis, and feels comfortable ordering lab tests, x rays, and over-the-counter medications will revel and thrive in the nursing home environment. This is not to say that this nurse is a nurse practitioner or clinical specialist. And this is not to say that this nurse is practicing primary nursing. I am describing the reality of the practice environment in nursing homes.

One of the most difficult aspects of being a nursing home nurse is the management of the nonprofessional staff, i.e., the aides. It is all too frequently this aspect alone that will drive away a nurse with excellent skills and knowledge. Directors of nursing are becoming acutely aware of this. As a result, they are expending as much effort on developing the image, self-esteem, and team comradery of the nurse assistant as they are in building the confidence and skills of the new or experienced nurse. During the interview, one tries to get a sense of the applicant's comfort with leading and managing.

The usual delivery system is a variation of team nursing in which one nurse gives medications, another does treatments, both handle paperwork, and both supervise staff. Concomitant with this are unit level conferences, patient review, and on-site teaching with the staff. Clearly, LTC facilities need nurses with experience, maturity, and the wisdom of Solomon, and we try to recruit for all of it.

The professional practice environment should be, but more commonly is not, one of research, education, and joint policy development. Those nursing homes that have standing nursing committees are noting this in their recruitment drives. And if you will forgive the editorializing, those nursing homes that do not have a professional practice environment should make haste to create one -- and not just in response to the nursing shortage.

In that same vein, more and more nursing homes are identifying the "nonnursing tasks" and hiring people to handle them. This is less common in the proprietary sector. "Those who got it, flaunt it."

It is not at all uncommon to hear applicants respond in this way when they are asked in the interview about why they would choose to work in a nursing home: "I do not want to work as hard as I do in the hospital." There is no question that many nursing homes can accommodate this desire. But, by and large, given an average unit size of 40 patients, and some of these patients have IVs or naso-gastric tubes, or are en route to the hospital, the nursing home is no longer nirvana.

ORIENTATION OF THE NEW "RECRUITS"

As described during the initial interview so that there are no surprises -- although there is usually culture shock -- orientation is 5, 7, or 10 days; it is rarely longer. This is a critical aspect of the recruitment process inasmuch as LTC facilities frequently get nurses returning to nursing. The tendency, therefore, is to highlight the high technology updating, which occurs during orientation.

In many facilities, a peer "buddy" is linked up with the orientee; this nurse will remain buddied with the new nurse at least through the third week. During this week, the new nurse will be on the nursing unit full-time. Lacking the number of staff -- let alone time -- to provide a more structured preceptor type of relationship, this is a most salutary mechanism, particularly in the smaller, less frenetic nursing home. In larger homes or where the shortage is very acute, the new nurse tends to get lost in the rush to get this nurse on board to "do" nursing. In urban settings, feedback from orientees who leave the job indicates that the impersonality and lack of warmth of the environment drives them away.

RECRUITMENT HYPOTHESES AND STRATAGEMS

Listed and briefly described below are structures and methods which are starting to be used in LTC with varying degrees of recruitment and retention success. As we all know, it is one thing to get them in the door and quite another to keep them. We need to deliver on what we promise. Keep in mind that the size and sophistication of the nursing home (e.g., with full-time medical doctors (MDs); or a teaching nursing home) are variables which will affect feasibility and success.

Short-Range Strategies

1. Operating on the assumption that today's nurses like high technology, if only in modicum, nursing homes are bringing in the pumps and wires, sometimes by design, sometimes by default. There has to be adequate in-service training, of course.

2. Concept of the physician and nurse as leaders of the team: joint decision making, collegiality, dialogue. It has been my experience that many nurses are not comfortable talking with physicians. Many do not have the command and knowledge of the language and many do not know how to describe a patient's status beyond vital signs, obvious physical distress, and/or discernible behavior changes. Many are unaware of the import of lab data and the more discrete signs and symptoms.

3. Seminars, in-house: the health team; outside lecturers. Must be given on all shifts; use videotape.

4. Queen for a Day. I have not come up with a new title for what, admittedly, appears to have a sexist connotation. Given the few areas of specialty nursing in geriatric institutional LTC nursing, the nurses see a very narrow career ladder and it is usually an administrative route. We have suggested -- and scheduled, at their request -- 3 to 5 days of working with the rehabilitation nurse, home health nurse, in-service education staff, and nursing supervisor. Even if the nurses do not move to the special area, at least they do not feel cheated out of the experience or option, in-house or in moving on. These experiences also serve to heighten their appreciation of what goes on and, in two cases I know of, stimulated the nurses to continue their professional education.

5. Research needs to be done using the staff's input. A negative by-product is that staff perceive it as more paperwork.

6. Nursing committees, as mentioned previously.

Intermediate Strategies

1. Nursing school affiliations: using the nursing homes -- skilled nursing facilities (SNFs) -- as a clinical campus. The SNF has to go out to the schools and make a presentation with regard to the advantages of the SNF being host. Historically, the nursing homes tend to recruit many associate degree graduates via this route.

2. The refresher course is difficult to get approved and off the ground. Works best with university or hospital affiliate. Even if the "returnee" does not come to the SNF immediately, it builds the reputation of the home with potential for future.

3. Student nurses for summer relief staff, as nurse assistants or LPNs.

4. Student nurse interns. Hire students who have completed the medical/surgical class and clinical work to supplement the nurse (RN/LPN) staff, to help with enteral feeding, treatments, and new admission assessment. Can be paid by stipend arrangement; student might receive "credit" for this experience depending on the arrangement between school and SNF. Needs strong in-service staff.

Long-Range Strategies

1. Junior high and high school awards to students who have done a project (or the like) on a health-related topic. The award presented in the name of the nursing department.

2. School nurse. In those school systems where this position has not been excessed, the nursing home invites itself as a guest speaker on a topic of interest.

3. Scholarship awards to the LPNs and nursing assistants for RN programs. In the New York City area, a 2- to 2 1/2-year RN program, National League for Nursing (NLN) accredited, will cost approximately $3,200. We are exploring using the NLN prenursing exam as a means to select the recipients who would be on contract with us to return "x" years of service after completion/graduation/licensure.

4. Medication technician. While I realize this subject is anathema to some of my colleagues, I feel we need to look at alternate ways of nursing. I would rather have my nurses bending over the patient than bending over the medication cart. A model for this exists in New York State psychiatric hospitals. Oddly enough, there is no official curricula; it appears to be institution-based and certified (...which is

what I feel I am going to be if the stress associated with the shortage is not relieved).

RESPONSE TO
RECRUITMENT STRATEGIES IN NURSING PRACTICE PANEL

Respondent: Susan Sherman, R.N., M.S.N.
Community College of Philadelphia

Recruitment and retention require an equal amount of emphasis. Most hospitals have focused on recruitment and meeting the needs of the novice group, or those nurses seeking employment directly out of school. The experience of some institutions, such as Boston Beth Israel, which have supported experienced nurses with opportunities for growth in the professional role with continued salary increases, demonstrates the importance of retention plans.

In regard to recruitment, many community college students do not have the same career aspirations as those of us who have been in the profession for a longer period of time. Recruitment strategies should recognize the goals of these students who often value benefits such as child care allowances or low interest car loans more than the standard retirement plan.

Licensed practical nurses and nurses' aides working in long-term care settings are potential recruits for associate degree programs. Many of them are women whose potential was not recognized when they were younger. Through partnership activities they can be introduced to the academic environment and encouraged to pursue a nursing degree. Remedial and support services should be provided to these students to ensure their success in the program.

Nurse educators have mistakenly focused a recruitment role on high school counselors. They have not always been our best allies. More outreach recruitment activities should take place with high school science teachers instead because of the emphasis nurses place on an applicant's science and math background.

Staff nurses serving on nurse recruitment committees is an idea with much merit. This is especially true if this activity receives credit in the clinical advancement reward system.

One factor to be noted when considering retention strategies is that lateral movement potential in addition to upward advancement opportunity is important to a large group of nurses. Many nurses who grow dissatisfied in their current positions would stay in the same institution if given the opportunity to move from one work assignment to another.

RESPONSE TO
RECRUITMENT STRATEGIES IN NURSING PRACTICE PANEL

Respondent: Sheila A. Ryan, Ph.D., R.N., F.A.A.N.
University of Rochester

Marketing has been defined as an ability to convince buyers or consumers that they cannot afford to go without a product or service. As nurses we must be clear who those buyers or consumers are, and they are many: chief executive officers, insurers, students, students' families, patients, patients' families, and so on.

The best recruiter is a satisfied, stimulated, growing professional nurse who knows that he or she is making a difference. This is the best recruitment strategy as well.

The marketplace will rapidly resolve any problems around compensation and scheduling for new recruits. A continued focus on financing the front-end entry level will only add to our problems. Attention should be focused on the longer term compensation issues for more experienced nurses.

Comparative studies are needed to look at working conditions for nurses in institutions that provide effective models of professional practice and those that do not. Central questions to address are: a) How much do institutions value the essential nature of professional practice? b) What systems are in place to reinforce that value? c) What makes professional practice models work in some places and not in others?

The issues of generalization and specialization should be critically examined from the perspectives of nursing education and practice. Specialists need access to general nursing knowledge and generalists need access to specialized knowledge. Decision support systems should be developed for nurses in practice that make use of computer technology. Faculty should be involved in the development of these computerized knowledge bases.

Affordable and effective career development pathways that combine experience and education should be developed. Career development might be facilitated for nurses in practice if ways could be established for them to earn credits that could be "banked" toward a future degree in nursing.

Money for education is an essential component of career development. Nursing professionals must be as current and up-to-date as possible yet hospital systems are cutting continuing education and inservice budgets. The costs of down time, turnover, orientation programs, and others should be looked at and related to the institutional budget and decision-making activities.

Educators must be involved in organizational systems and the activities of policy-making, decision analysis, and the structuring of environments that support innovation. As educators we have to consider how we are teaching these issues to today's students.

SUMMARY OF DISCUSSION AFTER RECRUITMENT STRATEGIES IN NURSING PRACTICE PANEL

Increasing the professional satisfaction of nurses to aid in recruitment was discussed in relation to models that extend hospital nursing practice beyond the institution. Primary nurses in some institutions have begun to move with their patients into the nursing home or community in an informal way during the transition to facilitate continuity of care. Because of the increased satisfaction, efforts are underway to establish more formal mechanisms to support this practice as part of the evolving role of the professional nurse.

Recruitment and retention strategies identified in the recent followup to the Magnet Hospital Study were reported. These include:

a) an exempt salary status that promotes a professional image by employing a nurse to do a job rather than to work hours;

b) use of self-contained units with no floating or very limited floating of nurses to other units;

c) providing rewards for educational advancement and upgrading to professional practice;

d) selective hiring practices that only bring in nurses who espouse the professional values the organization is promoting;

e) a self-governance model at the staff nurse level; and

f) a decompression of salaries so that clinical practice is rewarded through salary increases with a resulting wider salary range for nurses at the bedside.

RETENTION STRATEGIES IN NURSING EDUCATION

STUDENT RETENTION IN ASSOCIATE DEGREE NURSING EDUCATION

Paper Presented By: Gerry Hansen, Ed.D., R.N.
Weber State College

In preparing for this panel, I gathered information from two primary sources. The first was personal experience in the recruitment and retention of students and the second was a review of the literature. The literature is abundant with reference to recruitment and retention of graduate nurses but is not yet as rich in material about the recruitment and retention of students.

According to the data gathered by the National League for Nursing (NLN, 1988), there are 776 associate degree nursing programs in the country with 60 percent of them, or 471 programs, accredited by the NLN. For the past 4 years there has been a decline in the number of students enrolled and a corresponding decline in the number of graduates from these programs.

STUDENTS IN NURSING ASSOCIATE DEGREE PROGRAMS

	Enrollments	Graduations
1983	109,605	41,849
1984	104,968	44,394
1985	96,756	45,208
1986	89,469	41,333

In examining retention strategies for nursing students, the composition of the student group needs to be examined in order to assess any special needs that may be present. The associate degree programs traditionally have attracted older students, men, and minority students. The average age of the student in our program is 28 years of age. Over 50 percent of these students are married; a significant number of these students are heads of households and single parents. Approximately 75 percent of the students work. The majority work part-time but some work full-time while attending school. There are tremendous pressures on these students as they progress through their educational programs. Financial problems, child care issues, time scheduling, fatigue, and burnout can all contribute to student dropout and have an impact on academic and clinical success.

In examining the issues surrounding student retention, I believe that the most important area to examine first is the philosophy of the school of nursing toward its students and how this philosophy is transmitted to the individual student. Is it the goal of the faculty to assist the individual student to succeed and to graduate? Most educators would say that the answer is obvious and that it is foolish to ask. However, I believe that many students and graduate nurses can offer examples to the contrary. It is not an uncommon complaint among students that there appear to be many blocks to them succeeding in their programs. An attitude of "do it our way or not at all" still prevails in some nursing programs. How adaptable and flexible is the program to meet the needs of the students as far as class times, clinical schedules, and attending part-time vs. full-time? I believe that it is imperative that faculty members examine their requirements, schedules, and other policies in the light of impediments that work against the student succeeding without undue stress and hardship.

Pugh (1976) stated this as:

> "The central focus of the teacher's efforts should be to develop a relationship and to create an atmosphere conducive to self-motivate personally maturing, significant learning. To deal effectively with others requires a sensitivity to how things appear to the other person. It is, therefore, vital that the teacher be learner-oriented."

The work that has been done by Phillip Kalisch (1988) in the recruitment and retention of nurses indicates that nurses seek the following things in employers:

1. To be treated as a professional.

2. Interesting and challenging work.

3. Positive environment -- cooperative coworkers.

4. Independence -- autonomy.

5. Flexibility in scheduling.

6. A sense of performing an important and necessary service.

7. Responsiveness to their needs.

8. Socialization.

A close parallel can be drawn to the needs and desires of student nurses. In a recent study on effective teaching behavior, Ripley (1985) listed four invitational teaching behaviors identified by students as critical behaviors in faculty. These were:

1. Demonstrating understanding in working with students.

2. Going into the problem situation with students.

3. Accepting students as individuals.

4. Working for understanding.

Jacobson (1966), in an earlier study, listed six major categories relating to nursing faculty that were identified as important to students:

1. Availability to students.

2. Apparent general knowledge and professional competence.

3. Interpersonal relations with students and peers.

4. Teaching practices in the classroom and clinical areas.

5. Personal characteristics.

6. Evaluation practices.

Both of these studies established the importance of the student and teacher interaction in the educational process. The conclusion may be drawn that one of our most effective retention tools is the faculty member who demonstrates sincere interest in the individual student.

Close contact with the student in advisement and counseling is of prime importance. Problems, both personal and academic, can be identified early and measures can be undertaken to remedy them. We have had success in student retention by developing a student tutoring system. Quiz sections have been set up in certain topics for small group study with individual tutoring as needed. Schedules for classes have been adapted to meet the needs of students. Late afternoon and evening classes help meet the needs of the working student with family responsibilities. There has been a lack of mentoring in nursing in the past. I believe that example is the greatest teacher. The role modeling that is done by faculty members in their day-to-day relationships with students carries a powerful message.

If we want behavior that is professional and caring in our students, it is our responsibility to model this for them from the beginning. As we become more competitive for students, schools of nursing will need to foster an atmosphere that is found in other professional schools. Other disciplines tell their students, "You will be the decision makers." Nursing students are not given that message. Until this time nurses have been rewarded for being passive rather than assertive. As our practice moves toward increased autonomy students will have to become more assertive out of necessity. Faculty will have to deal with that behavior and promote it in students.

Financial aid is another aspect of student retention. As Federal funding becomes increasingly difficult to obtain, nursing programs will have to become more aware of raising funds for scholarships and student loans. Working with college or university development offices will become more common for nursing administrators out of necessity. Student retention often lies in the financial realm and it will become more of a responsibility of the program to assist the student in locating funding.

In conclusion, student retention brings into focus the responsibility of the faculty and administration to offer a support system to the student that will help to mitigate the stress of nursing and nursing education. Much of the stress that students face is inherent in nursing -- dealing with families in crisis, witnessing suffering, and carrying the responsibility for the care of the patients. Cobb (1976) has described social support as "information leading the individual to believe that he is cared for and loved, esteemed, and a member of a network of mutual obligations." And further:

> "This social support is typified by reciprocal interpersonal exchanges that enhance security, mutual respect, and positive feelings. It is human contact and caring, the 'high touch' side of high technology. People who experience social support are better able to withstand the stresses of their environment."

As we offer this support to students, I believe that retention will be affected in a positive manner. Flexibility and adaptability to students' needs will also be an important contribution to retention. It is highly unlikely that the competition for students will decline. The shortage of nurses is here and the issues surrounding recruitment and retention must be addressed head-on by the profession.

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RETENTION STRATEGIES IN NURSING EDUCATION

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Efforts to recruit and retain students in nursing education programs create areas of delicate decision making and continuing conflict. Precipitous action prompted by a panic response to the nursing shortage could, over the long run, lose us more than we gain. Straining to increase numbers could erode the intellectual integrity of the discipline and create a generation of practitioners without the personality characteristics needed to deal in a positive manner with the critical issues facing us. On the other hand, though we do not totally own the shortage problem, we should be most knowledgeable and active in proposing solutions. If the profession does not move to socially relevant action, the shortage will be resolved by others.

DEFINING THE PROBLEM

Based on the data on nursing majors in baccalaureate programs for 1982 to 1986, we can say that over half (52.4 percent) of them leave. There was a 14.6 percent attrition rate of students in associate degree programs in the same period. The fact that graduations from 4-year programs have slightly increased or remained the same while associate degree graduations have declined, is due to a baccalaureate replacement factor which almost equalled the defection rate. Generally, students who transferred to the nursing major in these instances had nonmedical majors or had not declared their major. Students leaving the nursing major most frequently complained about the rigidity of structure that leaves little latitude for creativity and flexibility, and the unexceptional intellectual capabilities of their fellow students. Successful baccalaureate graduates were generally characterized by a high tolerance for structure (Green, 1987). The author would add that those with a high tolerance for structure may also have a low tolerance for the ambiguity of practice and may be easily disillusioned as they enter the work force, fall prey to sloppy practice habits, and build a tenuous commitment to the discipline. These relationships should be studied.

Any discussion of educational recruitment and retention must include two critical events that have characterized the period since 1980. High school graduations were at their peak in 1980 due to the tail-end of the baby boom generation. But a dramatic decrease in the high school population after that year seriously limited the recruitment pool for collegiate and university education. A new era in the economics of health was heralded in 1983 with the advent of the Prospective Pricing System (PPS) of medicare. By the influence PPS exerted on reimbursement, it forced hospitals to operate with a bottom-line mentality. The labor-intensive nature of hospitals made it convenient to balance the budget through personnel cutbacks. Additionally, fiscal solvency has become contingent on increasing occupancy rates, short lengths of stay, and a high number of admissions. Though there were some initial attempts to reduce the nursing work force in hospitals, it quickly became apparent that nurses were versatile workers and contributed directly to shortening the length of stay and increasing the number of admissions. In the past 14 years, there has been an 82 percent increase in the ratio of registered nurses (RNs) to patients in acute care (Aiken, 1987). Other salaried provider professionals, ancillary workers, and support staff have been cut to the bone, causing nurses to expand their activities both laterally and vertically. The end result has been an increased demand for nurses and a stressful hospital work environment with nurses often being left little time to nurse. Two-thirds of nurses are employed in hospitals. This situation has been publicized in the media, and creates an image of nursing as a field of work that should be avoided. For nursing, this growing negative image has probably been a greater liability than the development of a limited number of high school graduates available to enter the field. In recent years there has been an observable pattern of fewer inquiries about nursing as a field of work, of fewer applicants to schools of nursing, and, most recently, of declining admissions. Despite this trend, schools of nursing have experienced a relatively stable number of graduates. One can only wonder about the quality of students. Are we straining too hard to maintain our enrollment levels? Are we attracting and retaining our share of the best and the brightest?

Nursing may be attractive to candidates from a less traditional recruitment pool. At Rutgers University we have already adjusted to this reality. Of students admitted to the College of Nursing in the past several years, only about 35 percent came directly from high school. Our student population is largely college graduates or transfer students who wish to prepare for another major, individuals making midlife and even later life career changes, and students with special learning needs to whom the college and university have a commitment. Rutgers College of Nursing is distinguished by having the most successful economic opportunity program in New Jersey. This program is designed to assist talented students who are educationally and economically compromised. Students are provided with remedial help in the basic skills area, faculty-assisted seminars to complement both the supportive sciences and the nursing major, tailored counseling services, and courses which prepare them specifically to serve urban populations. One of the many strengths of the program is the maintenance of strong ties with alumni who mentor students and later help them get access to practice opportunities as graduates.

RETENTION STRATEGIES

Retention strategies must be tailored to the educational program's recruitment pool. The intellectual capacity of the students and the national, state, or local flavor of the student body are examples of variables. Whereas recruitment approaches are tailored, academic standards are derived from the discipline. Despite rigorous standards, it is possible to decrease the barriers which exist in getting an education. The first step is to intrigue the best and the brightest with the work of nursing. There is no work that is more physically and emotionally demanding, complex, and diverse than nursing. As we create new models for course offerings and academic progression, nursing may hold more appeal for the best and the brightest. Flexibility need not compromise quality. In these days when many students juggle multiple roles and face economic and personal hardship in the pursuit of an education, every attempt should be made to remove barriers. Flexible scheduling has become a prerequisite. The nature of that scheduling should depend on the needs of the students in question, or on what appeals to your recruitment pool. Summer sessions, and night and weekend courses are obvious conveniences. Advanced placement, challenges, and the assessment of life experience for credit also facilitate progress and reinforce the image that the school is interested in the student. Internal course flexibility is a prerogative which faculty may exercise. Nursing has long predicated its educational system on a competency-based philosophy which should allow courses to be self-paced. Where faculty are reticent to use such strategies, the point should be made that such accommodations are within their academic freedom.

Professional and interpersonal relationships between faculty and students are the most potent retention device. Assignment of students to advisors should provide continuity. Faculty should be expected to know their advisees personally. They should feel good about what they contribute to a student's success, about their field of work and the discipline of nursing, and about the emotional bond that exists with their students. Nurturance and individual servicing of students can remedy many problems that eventually result in defection from the school.

Many students decide to change their area of study because they find that either the work, or the curriculum which prepares for the work, is not as they had originally imagined. It becomes critical to survey the expectations and imagery held by a specific cohort of students and more generally by individuals in the pool from which the school draws. It is logical to start the educational experience at the point where students are in their thinking and expectations, rather than investing in changing their point of view. Such data would help to make determinations about whether to start nursing early in the course of studies or limit nursing experiences to the upper division, whether to start with experiences in health versus illness, or to combine both of them in some manner. In the cognitive domain, profiling the recruitment pool could pinpoint the appropriate level of conceptualization for the curriculum and the group's tolerance for dealing with process in its pure form or whether process must take a back seat to content.

It is critical to provide a clear view of what the nurse does because students look at the ultimate goal of work that is personally satisfying and economically rewarding. A clear and cogent practice framework for the curriculum seems more necessary than ever. A practice framework should not be confused with a conceptual framework. Consumers value nurses the most for their ability to care and give comfort, and for their technical competency. These understandings should drive the educational program. The learner should be able to distinguish patient care from nursing care which is but one aspect of the larger mission of patient care.

SOCIALIZATION INTO THE FIELD

I would like to offer the work of Hildegard Peplau as a theoretical orientation for socialization. Dr. Peplau crafted an experiential model for psychiatric nursing which emphasizes the relationships between perceptions, feelings, thoughts, and actions. Often the strongest link to a situation is the emotional link. Socialization into the field can be very fruitfully initiated with an emotional link to the world of nursing. Beginning socialization from this perspective demands that nursing be presented as exciting and that there be an obvious pride in the work the nurse does. As students make this psychic investment, they will find stronger linkages to their peers and a growing identity with the field. Faculty enhance this emotional link.

Networking to fellow students and the discipline at large through the student nurse association strengthens this link. Rutgers University allocates an amount of money to each of its schools to be used for student programming. Decisions on how this money is used are made by the student government within each school or college. Rutgers College of Nursing students have chosen to pay half of the membership fee in the student nurse association out of this money for any students who wish to join. Since this policy began, the size of Rutgers chapter of the National Student Nurse Association (NSNA) has grown dramatically, as has the participation of our students in the programs of the state and national association. Currently, the president of the NSNA is a Rutgers student.

The dramatic change that occurs in students, faculty, and agency staff once they are exposed to new ideas and experiences through nursing organizations is worth commenting on. A similar strategy has been used in the Rutgers Teaching Nursing Home. Clinical agency leaders and faculty who resisted innovation and experimentation have been dramatically influenced after being introduced to social and professional experiences beyond their work setting. Nurses are often content with a limited view of the world. Whereas knowledge liberates the mind, exposure to the broader discipline through its organizations liberates practice. Though the emotional link with the discipline may provide the initial glue to hold a student's interest, it is no substitute for relevant practice experiences. Nursing is a practice discipline and good quality clinical experiences in sufficient quantity are necessary to establish the credibility of the education. Quality agency settings and a structure within which one can practice are pieces of this, but probably the most significant element is appropriate role models. Faculty are not the role models for students. They are mentors; they are nurturers; but they are not role models.

Service settings which provide the context for clinical learning create a real liability for nursing education. Ellen Fahey has been quoted as comparing curriculum revision to moving a cemetery. Dr. Fahey's analogy may well be correct, but in reality nursing education has moved further than nursing service. It is retrogressive to teach to that which currently exists in most delivery settings. Nursing has been sacrificed and victimized by the economic pressures of recent years. There has been limited ability to control our own destiny, since nursing service leaders are not usually positioned for power and control. Given this situation and the fact that without adequate practice experiences students quickly become disenchanted and question their occupational selection, faculty must invest in reshaping service delivery. Simply put, it will be impossible for nursing to realize a better future without segmenting the workplace to recognize education, experience, and other factors that should be linked with a hierarchy. These distinctions are most directly accomplished through clinical ladders and job descriptions.

It is important for students to be involved in settings where nurses nurse. This can only happen where support systems are adequate and where nurses have control over the environment where care is delivered, and over the resources which are available to deliver that care. I do not mean to promote any one system to bring education and service together, or to propose strategies commonly labeled as unification or collaboration. Rather, I offer the observation that faculty must invest in creating an adequate practice setting for their students. In these days of panic over retention, the placement of students becomes a retention device. Faculty should demand certain concessions from clinical agencies in order to create the best climate for learning. Faculty who are ready to give freely of their time through service on committees, staff development, and consultation can strengthen the position of nursing service administrators as they fight to be heard.

Socialization into nursing can also be enhanced through a variety of educational techniques. Many of these have been tested and described in the literature. They must be further evaluated in terms of the degree to which they enhance retention, the job satisfaction which students experience following graduation, the longevity of graduates in the field, and whether education incorporating these strategies results in graduates who ascend to leadership positions. Synthesis courses and work study programs should help to ease the transition to the work role and support retention by creating a link to the real world. Creating student work experiences with agencies that are influenced by the college is a similar strategy. The "one-room schoolhouse technique," accomplished through the assignment of new and advanced students to the same clinical areas, can provide comradery and a view of the future that promotes retention.

With a view to educating for the work of a profession, there are practice characteristics which should be initiated early in the educational process. Students should be expected to make independent decisions based on data, to practice autonomously within their level of competence, and to actively participate in peer review. An opportunity for specialization, as distinguished from the preparation of the specialist, should be afforded within entry-level programs for professional nursing. All nurses specialize once they enter the work force even if they do not pursue graduate education to become specialists. This is more than a play on words. Problems with the cross-training of personnel and resistance to floating are no more than empirical validation of this relationship. Further verification of the appropriateness of this strategy can be derived from the American Nurses' Association's generalist certification in the specialty practice areas. Finally, we should not become so self-centered that we lose sight of things that have worked well for other disciplines. Medicine and law have succeeded in socializing their students through a concentrated course of studies building on preprofessional education. I am reticent to suggest the number of years for either preprofessional education or professional study, but the concept holds merit and should be explored.

SUMMARY AND CONCLUSIONS

It is obvious that nursing education cannot proceed as it has in the past in view of the large number of students lost through attrition. The changes suggested in this paper are simple and would not require the dismantling of educational programs. More radical changes may be merited to complement the evolving health care delivery system and to assure a future role for nursing. That topic is beyond the focus of this paper.

Nursing education has to some degree accommodated the times and the policy decisions of the profession. To promote its own agenda, organized nursing is vigorously pursuing statutory change to standardize and control the field. The workplace has done little to control its destiny. Public policy usually reflects the times instead of creating the direction of change. Once the workplace is restructured and nursing is provided control over its resources, public policy will move to reflect those patterns that have proven useful and graduates will experience less disillusionment as they enter practice.

The observations and strategies proposed in this paper build a strong case for funding educational research. We need to know more about those who enter nursing and successfully complete educational programs. We need to know more about the educational techniques which promote leadership development and longevity in the field. Educational research has been largely ignored in recent years with funding being channeled into direct student aid and clinical investigation. The author does not mean to minimize the need for student aid. An infusion of money directly to students is timely to begin to "prime the pump" and attract students back into the field. It is unwise to respond to the demand for nursing without some serious consideration of how closely the demand corresponds to need. Given a restructured system for providing services, supply may be adequate to address need. The mosaic has many delicately interlocking pieces.

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RESPONSE TO RETENTION STRATEGIES IN NURSING EDUCATION PANEL

Respondent: Maryann F. Fralic, R.N., M.N., Dr.P.H.
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My perspective for this presentation is primarily as a nurse executive in a large tertiary-care university hospital. Since I also hold a joint appointment with the Rutgers College of Nursing, I will attempt to reflect both the service and the education perspectives.

The education of nurses must be real insofar as the work, the hours, and the schedules are concerned. Joint appointments must be cultivated and emphasized. Some special continuing mentor relationships with excellent staff-level clinicians must be developed for students. There must be school/agency collaboration to share recruitment commitments and efforts.

We must also think of new ways of financing education for talented potential students. We must study which teaching/learning modalities are superior. We must have meaningful and substantive transitional experiences to guide students through the critical period from student nurse to competent practicing nurse.

Nursing education, like administration and research, is a support service to the practice arena, either directly or indirectly. Nursing education must focus on preparing nurses for practice who have reasonable assurance of success in the field. We need to determine the situation in the practice setting today, and what it probably will be like in 2 years, 5 years, and 10 years. And, then, we must determine how nursing will be successful and preeminent in that system.

If we read our environment well and plan thoughtfully, education will prepare a student systematically, realistically, and philosophically. The result will be a successful practicing nurse. That will then have an indirect but very positive impact on overall school of nursing recruitment and retention.

We need to improve our public image. We need to showcase what it is that skilled, thoughtful, theoretically-based nurses do -- daily -- in their professional practice. The caliber, dimensions, and complexity of the almost instantaneous and life-impacting decisions that nurses are called on to make -- and willingly make daily -- are not put into the media forefront. The collegial, interdisciplinary, and interprofessional nature of nursing practice is impressive, unique, and meaningful. We need to tell that story very clearly.

We have not adequately tapped those nurses who would eagerly say, "Yes, nursing is hard work, it is long hours, it is stressful, but -- there is nothing else I would rather do!" That sells, that influences, that melds the realities with the intrinsic rewards. And that is what we have not successfully managed to do, the melding of reality and reward.

RESPONSE TO RETENTION STRATEGIES IN NURSING EDUCATION PANEL

Respondent: Dorothy Kleffel, R.N., M.P.H.
The Visiting Nurse Foundation, Inc.

Home health care contributes to nurse retention because it is more oriented to the professional model of practice than nursing in most other types of settings. Nurses come to us from hospitals and report that it is more satisfying to practice in home health because there is less physician domination and they have more autonomy and opportunities for independent decision making. Nurse satisfaction concerns us because we do not want nurses to leave us and possibly the nursing practice altogether.

Our agency is committed to maintaining close relationships with local colleges and universities. We offer student placements for nursing students who need a clinical experience in home health care. Since these students and their nursing faculty collaborate closely with our nursing staff, we believe the experience helps academia keep abreast of the rapid changes that are occurring in contemporary home health.

At the Visiting Nurse Foundation, the mechanisms are in place for joint appointments with the University of Southern California (USC) School of Nursing. I am the Director of Education and Research at VNF and also function as a faculty member teaching classes in home health care and quality assurance in home health. We also conduct joint research projects. Currently, a USC faculty member is conducting a project at our agency.

We are one of over 140 home health agencies in Los Angeles County that actively compete to recruit new staff nurses. In addition to promoting the issue of job satisfaction, we are planning a more attractive benefit package. One unique benefit that we plan to offer in the near future is a car allowance of a monthly stipend in addition to mileage reimbursement.

Tuition reimbursement and release time to pursue an advanced degree are other important benefits we offer our nurses. These are particularly relevant to many of our staff because they cannot advance into administrative and supervisory positions without a baccalaureate degree and Public Health Nurse certification.

Nursing costs are unbundled in home health care. Our agency makes over 2000 visits each year and over half of these are nursing visits. A pay per visit system is under consideration at our agency to replace having nurses work on salary. This will allow more individual control because nurses will have the freedom to accept or not accept visits provided, of course, that all patients' needs are met. This also provides more flexibility for nurses who will be able to choose whether they wish to work overtime to earn more money.

Most home health agencies do not hire new graduates right out of school. At our agency we prefer that nurses have a minimum of one year's experience to develop their nursing skills and professional judgment. Nurses work very independently in home health care. They must have excellent skills in the assessment of physical health status, home environment, and family dynamics. They must provide case-management services and linkages with other community agencies and they must work with various medical technologies. They must also provide patient teaching and supervision to home health aides and family members. Nurses also need good writing skills to provide adequate documentation for reimbursement purposes.

Successful home health nurses assume active, empowered roles within the health care system and community. Because they work in a constantly changing environment, they are flexible and possess a sense of adventure and humor.

SUMMARY OF DISCUSSION AFTER RETENTION STRATEGIES IN NURSING EDUCATION PANEL

Several strategies for retention were discussed. One called for a partnership between the educational and clinical institutions. It was proposed that experienced staff nurses serve as preceptors for senior nursing students for an indepth clinical experience. Also explored was matching a beginning nursing student with a more experienced one.

There was also discussion that the health care industry has changed from being viewed as a "social good" to an economic enterprise. It was suggested that student experiences should stress that it is no longer a matter of delivering the best care ideally possible but rather a matter of deciding what is the best care possible under a given set of conditions with the available resources.

It was reported that small hospitals in Utah, primarily a rural state, had faced a severe nursing shortage about 10 years ago. Representatives from nursing education worked with the hospitals to develop a statewide strategy. They targeted licensed practice nurses (LPNs) as the recruitment pool for associate degree nursing programs. Instead of requiring these prospective students to come into urban areas for their education, the nursing programs were moved to the rural communities. These programs have been in operation for over a decade and have been highly successful. Rural hospitals now report a nurse retention rate of 85 to 90 percent.

In contrast to most other areas of the Nation, nursing education programs in Utah continue to be flooded with applicants for admission. This was attributed to publicity that has been generated by a survey done in the State about 5 years ago that predicted a shortage of over 2000 RNs by 1990. However, nursing education programs are faced with serious fiscal problems and are only able to admit one student for every four applicants. The need for increased funding to support nursing education was identified.

RETENTION STRATEGIES IN NURSING PRACTICE

NURSE RETENTION: LONG-TERM AND SHORT-TERM STRATEGIES FOR IMPROVING NURSE RETENTION AND PATIENT SATISFACTION

Paper Presented By: Edward J. Halloran, R.N., Ph.D., F.A.A.N.
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CHANGING THE HEALTH CARE SYSTEM

We have to move away from looking at the solution to the nurse shortage as something that is unrelated to the larger health care system. For that reason, I would like to acquaint you with action taken at the National League for Nursing (NLN) convention this past June. The following resolution was introduced:

> "Whereas, the ill citizens of America are not invested in the competitive, fragmented, market-oriented health care system, and when faced with illness, they are often too vulnerable to make market decisions and
>
> Whereas, significant numbers of Americans, estimated to be as high as 40 million individuals in this country, many of whom are chronically ill, do not have access to the fee-for-service, market-oriented health care system, and
>
> Whereas, Americans will spend in excess of $0.5 trillion for health care in 1987. Yet for many Americans, important health care services are not available, and
>
> Whereas, the nearly 2 1/2 million nurses in the United States constitute health care professionals who work across the entire spectrum of health care and illness practice, in and out of institutions, and who are flexible enough to work where and when their patients experience need and help people, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death), that they would perform unaided if they had the necessary strength, will, or knowledge. Likewise, the nurse helps people be independent of such help as rapidly as possible.
>
> Therefore, be it resolved, that nurses support the prompt development of a universal, comprehensive, national health system for the United States of America."

That is what I believe is the real answer to the nurse shortage. Now, you did not come to Washington, DC, to hear that. There are some shorter term answers that I think are timely to take advantage of. The short-term answers apply much more to the opportunity that knocks only once or twice every decade. There is now an opportunity to develop programs that will have the impact of making nursing work appealing to people who would be nurses, only if the profession were socially acceptable. There are three changes that have been proposed for our own hospital:

a) changing the salary/working condition equation;
b) increasing the chance for a nurse's professional growth and opportunity; and
c) providing direct support for nursing education.

CHANGING THE SALARY/WORKING CONDITION EQUATION

First, we will change the salary and working conditions. I couple them because they are fundamentally related to each other. Many nurses take cuts in salary of $3,000 or $4,000 a year to go to jobs that have different working conditions. So, the working conditions are an extremely important part of looking at a salary and working condition ratio. They cannot be taken out of context. The salary situation, in which the nurse who has worked for only 4 years makes exactly the same amount of money as the nurse who has worked for 40 years, needs restructuring.

Our current salary structure parallels out indefinitely. We compete on the low end of the scale for new nurses and hire between 200 and 300 registered nurses (RNs) per year. We drive up only beginning salaries, and cause turnover.

Who has experienced little or no turnover? Teachers. Teachers have very successfully structured a progressive salary scale that is difficult to get off. They have made seniority a very important issue through their negotiations or collective bargaining. Most hospital institutions do not. Clearly, the large health care institutions in this country have little interest in seniority. They treat every nurse the same, and as a result, nurses are constantly turning over. Seniority benefits are important elements to be worked into the salary/working condition equation.

Rochester school teachers, for example, have a new 3-year contract that calls for the highest paid master teacher to make $70,000 per year. (That immediately caused one of the ranking professors in the School of Education at the University of Rochester to quit her job and join the staff of the public school system in Rochester). Rochester, not unlike many U.S. cities, is surrounded by very prosperous suburbs. The inner city is left pretty much to the poor, and as a result, the school system is not a very socially acceptable place to work. The school board and teachers have worked together to create an incentive for people to work in the inner city school system. Rochester teachers gave up their seniority rights to select their school assignment. The school system now assigns teachers to the schools where they are most needed. In exchange, the school system pays the best teachers (only 10 percent, selected by peers, are master teachers) up to $70,000. The Rochester example suggests a creative alternative to the dominance of seniority. Health care institutions must be more creative and career-oriented in their salary/working condition strategies.

The salary structures require a ratio of entry to retiring salaries of at least 1:2. Nurses with 30 or 40 years of seniority should be getting double what nurses are paid on entering the system. The 1:2 ratio ought to be maintained. Such pay practices will produce a longer tenure for staff, and longer tenure will have the effect of decreasing the need to recruit such a large number of new nurses every year.

The working condition element of the salary/working condition equation has to do with the assignment of time. If nurses on a ward were given the sanction to look creatively at a work assignment schedule, they could come up with something better than all sharing equally the 8-hour shifts, 5-day work weeks, shift rotations, and all weekend schedules.

Seniority can be introduced to distribute premium dollars or preferred time schedules. Incentives that produce either premium income or premium time offer nurses what is needed most -- choice. Each quarter nurses at the University Hospitals of Cleveland are given the opportunity to select income or time schedules. In a simulation of the choice between time and money, half of the nurses selected time and half chose money. The choice of a nurse may shift from time to money or vice versa. The choice to select one or the other, or a combination of both, affords nurses greater autonomy.

PROFESSIONAL GROWTH AND OPPORTUNITY

A second change to be made at University Hospitals of Cleveland concerns professional growth and opportunity. Our profession has limited opportunity for professional growth and development. Almost all of the opportunity that exists for advancement in the nursing profession causes one to leave the bedside. A nurse can be a teacher, researcher, consultant, or an administrator. But, if you want to advance, if you want to earn money, you have to move away from the bedside.

It is no mistake that there are proportionally more men in nursing administration. Men happen to be socialized, to be concerned about income, and as a result, they have pursued the income. I clearly believe that is the case in my own situation. I will, however, work diligently to give more opportunity for progression in nonteaching and nonadministrative clinical nurse positions.

Advanced clinical positions have often been associated with advanced degrees. You cannot be a clinical specialist until you have your Master's degree. While that seems right and justified, I also think that it would be incumbent upon nursing organizations to send people to get their degrees, and while they are in school, pay the tuition, and then bring them back as valued contributors to the health care system that sponsors them. Couple the expectation of advanced learning with the process of achieving it.

At a recent meeting of the American Organization of Nurse Executives in Los Angeles, Sarah Blackwood, administrator at a Kaiser Foundation Hospital, said that she sent 56 practical nurses back to school at the institution's expense instead of laying them off. Our health care institutions stopped paying for nursing education some time ago. Why not get them back in the mode of paying for it by sending talented staff to school as an investment in both them and the nursing school?

Job enrichment is also an important component for professional growth and development. When the hospital develops a new patient care program, a nurse practitioner is hired, since administrators often forget that five capable staff nurses are eligible for, and would like, increased responsibility. Send one of them back to school and gradually increase the job responsibility simultaneously. The beneficial effect would accrue to the nurse (a new job), the school of nursing (a new student), the hospital (a new patient care program), and the other nurses (they see hope for increasing their scope of practice when future opportunities arise).

DIRECT SUPPORT FOR NURSING EDUCATION

The third initiative being instituted at University Hospitals of Cleveland is direct support of nursing education. The Frances Payne Bolton School of Nursing at Case Western Reserve University is one of the most successful nursing schools in the country. It has been rated as the number one private nursing school in the country. It is an extraordinary place, yet it is exactly half the size it was 10 years ago, while the medical school is twice the size it was then. Because the size was cut, the school operates in the black. It should not surprise anyone that Cornell, Duke, or Boston University closed their doors. Private nursing schools have financial difficulty.

Nurses are predominantly women, and this country has had little interest in educating women. It is not anything new. It is merely the latest repetition of longstanding facts. If women want to get educated, they enter into fields where there is money for education.

To support nursing education, endow chairs. Why, for example, does Yale New Haven Hospital not endow a chair in nursing at the Yale School of Nursing? It is dependent on it for its leadership staff, and it provides excellent people. In 5 years, when there is increasingly greater competition for dollars, will the medical school continue to siphon off money at the current and disproportionate rate? Will the nursing school continue to shrink in size? Only if we let it happen. Direct support for nursing education through endowments and other means will prevent nursing schools from disappearing.

Salaries/working conditions, job enrichment, and education are all short-term objectives designed to stem the tide of the nursing shortage. The best long-term hope is for changing the health care system. I would submit that we should work on both simultaneously. Work to change the health care system and also to achieve the short-term, nurse- and hospital-oriented goals designed to achieve higher levels of nurse retention.

THE RETENTION PROCESS IN A COMMUNITY (HOME) HEALTH NURSING AGENCY
(IT'S YOUR BAG...OR IS IT?)

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> "An applicant may have the kind and amount of experience needed, be licensed to practice, and good references, but not do well."
>
> Lipsett, Rodgers, Kentner, p. 19, 1964.

The preceding quotation, although 24 years old, succinctly describes the situation of some community health nurses (CHNs). Why do they not do well? Why do they leave? What kind of nurse is leaving voluntarily or involuntarily? What can be done to increase longevity? In community health nursing, personality and interest factors, as well as technical and professional skills, are important for job success and long-term employment.

The applicant may be an excellent nurse, but does he or she like to take off and put on a coat, scarf, and boots 12 times a day, contend with dogs, cats, and even fleas, traffic detours, school buses, snow, rain, sleet, and less than ideal sanitary conditions?

JOB CHARACTERISTICS THAT CONTRIBUTE TO RETENTION OF STAFF

A "good" registered nurse (RN) may do better and stay longer if his or her interests, personality factors, and professional skills are matched with the job characteristics before the placement is finalized. But, in reality, supply and demand and other economic factors may make this type of selective hiring and placement impossible.

First, we do not know the characteristics of the "good" CHN. If we did, an applicant's profile could be compared with that of the successful nurse and used for selection, counseling, and placement. Therefore, I would like to suggest that a study of the characteristics of the "successful, long-term" CHN, as well as of the nurses who work in other areas, would be beneficial. The results of this study would be used to create a profile against which applicants could be compared. This would be another assessment tool in the selection process; it could also be used for placement and counseling.

Second, we have not profiled or published the job characteristics of the CHN. In 1975, as a graduate student in Community Health Administration at the University of Pennsylvania, I completed a Master's paper on personnel administration at the Wharton School. The purpose of this limited research project which used a convenience sample of CHNs was to describe job characteristics according to Glueck's (1974) "Nine Characteristics of Any Job." This sample consisted of graduate students in community health nursing and staff nurses in one home health agency (HHA). The profiles of the two groups were tabulated separately in order to compare the results. The two profiles were combined into one that represented the perceptions of the 23 nurses with reference to job characteristics.

The 23 nurses agreed on only 1 item, human interaction. All rated this aspect of their job as a "high" characteristic. Graduate students agreed on two characteristics -- human interaction and the psychological dimension of degree of responsibility. Staff nurses did not agree on the level of responsibility.

I found articles in the nursing literature describing studies to determine personality contrasts among medical-surgical nurses (Levitz and Michaels, 1965), personality structure of psychiatric nurses (Navran and Stauffarber, 1957), and psychological test characteristics and performance of nursing students (Johnson and Leonard, 1970). There was no reference to the personality structure of CHNs.

In an effort to profile the job characteristics of the CHN this year, I mailed the 1975 form to agency directors across the country in January 1988 and asked them to have staff members complete the form. Six agencies responded.

I did this small project because it seems reasonable to assume that if the "best" professional is placed in the "best" health care setting for that individual's personality and interest characteristics, the quality of patient care will be enhanced, the client will be satisfied, and the professional will be retained and enjoy job satisfaction. HHA nurses were the most logical individuals to provide information on how they view their jobs and why they have remained in this setting.

THE RETENTION PROCESS

Visiting Staff

Given the characteristics of the job and work environment, which of the applicants who is experienced, licensed, and with good references does the boss select? How is this decision made? What tools are used in the decision process? What are predictors of longevity? How well have community health agencies done in retaining their staff?

I sent letters to agency administrators in January 1988 and requested that they share their turnover rates with me. The responses included a range of 14 to 25 percent with an overall average of a 16 percent per year turnover rate for professional nurses. The reasons for leaving included personal ones, such as maternity leave or a move from the geographical area, and work-related ones, such as low salary, excessive paperwork requirements, and Federal regulation that affects the quality of care in a negative way.

Retention begins with the selection process. The application blank gathers information about education and work experience. The interview provides the opportunity for applicants to talk about feelings and attitudes that are important to them. Reference checks are important but have limitations since the applicants usually select their own references and those contacted may be hesitant to give honest evaluations. Also, the reference may have little value if the community health job is different from the last job.

In an effort to ensure retention with the Visiting Nurse Association (VNA) of Eastern Montgomery County, the applicant is subjected to multiple interviews and given the opportunity to ask questions. The Director of Professional Services (DPS) does the initial screening by telephone, if possible. This is to determine the applicant's work experience and interest in community health nursing and to inform him or her of the salary structure. This initial screening eliminates those nurses who are looking for a salary or position the agency cannot offer.

The first in-person interview is usually done by the DPS, who represents the agency's programs, services, personnel policies, salary, and weekend and 24-hour rotation. The facts about productivity standards, documentation, and medicare and other third party payor restrictions are discussed. The applicant completes a skills checklist. A second interview is scheduled if the applicant and the DPS are interested in pursuing employment.

A second interview is part of the process so that most of the clinical supervisors and the supervisors responsible for quality assurance, in-service, and orientation can meet the applicant. The supervisors present a realistic picture of community health nursing, including the pros and the cons. The applicant may also spend a half-day with one of the staff nurses making home visits. Staff members are free to share any information with the applicants. These work samples provide an accurate picture of the real world.

The followup usually comes a few days after this second interview. The applicant is then hired, or told that the job has been filled, or told that the process is still continuing.

This detailed interview and selection process, although time consuming, is relevant to the retention issue. New employees are not disillusioned. The supervisory staff knows what must be addressed during the orientation period to make the transition to home health nursing. This process also has potential for a positive or negative impact on the outcome. In January 1988, we saw both a positive and negative reaction to the job by different applicants. One applicant said she had been interviewed by several HHAs, but no one had laid out the facts like our supervisors. She decided she did not want to work in this type of setting. Another applicant accepted our position at a lower salary than offered elsewhere because she was impressed with the total interview process, the professionalism of the staff, and the honest statement of the pros and cons. She was ready for the challenge.

The important issue in 1988 is to interview all applicants who pass the initial screening. Although we are seeking nurses with skills in intravenous (IV) procedures, chemotherapy, and other high technology procedures, we are willing to work with qualified nurses who exhibit enthusiasm to learn new skills. This approach also contributes to staff retention.

I transmit the very positive nature of nursing in our agency to new applicants (I am biased). I tell them that although community health nursing is in a state of turmoil today, this agency is a good place to experience the turmoil.

But these initial processes alone are not sufficient to retain staff. There must be an ongoing reward and recognition system. Here is an outline of suggested policies.

Financial Recognition

1. Competitive salary structure.
2. Competitive benefit package: cafeteria-type benefits.
3. Personnel policies that provide for recognition of staff:
    a. Scholarship (tuition) fund;
    b. Certification recognition;
    c. Continuing education opportunities;
    d. Promotional procedures for the limited number of higher level positions;
    e. Time and one-half rate on weekends and holidays, regardless of 40-hour week;
    f. Buy back a portion of all of the unused sick time.

4. Career ladder possibilities. A hierarchy or criteria intended to provide a means for evaluation and development of professional nurses who are providing direct nursing care to patients (del Bueno, 1982). Whitney and Jung (1987) have described a career ladder for an HHA specifically that includes four levels of clinical nurses.

5. Merit pay system. In one agency, employees can nominate themselves by completing an application for committee review and decision. In 1987, 20 percent of employees received a merit increase for exceptional service.

6. Productivity incentives: bonus system. Example: Expected productivity is 5.2 visits per day. Ten dollars extra is available to staff for each additional tenth of a percent. The nurse who makes 5.4 visits per day would earn $10 x 2, or $20 extra for each day worked that month.

7. Increased salary for participation on IV team.

8. Sign up bonus.

Non-Financial Recognition

1. Emphasis on a philosophy of quality.

2. Provision for staff involvement with policy and procedure development.

3. Selection of "Nurse of the Year." At our VNA this is a peer selection process. The name of each year's winner is inscribed on a plaque and displayed in a prominent place. This selection includes media coverage through local newspapers, which is beneficial to the nurse and the agency.

4. Have a "Thank You Board" where letters of commendation are posted for all employees to read.

5. Annual recognition dinner for staff that is sponsored and supported by the Board of Directors. Those employees who attain designated years of service can be recognized at this time.

6. Recognition in agency newsletter.

7. Job-sharing opportunities: use of per diem or per visit staff.

8. Creation of positions, such as Senior Nurse or Intake Nurse, to recognize staff.

9. Annual award for exceptional merit. In one agency, this award included a pen set and $1,000.

10. Credit Union.

11. Recognition as a special individual. It is not unusual for me to hear the familiar strain of "Happy Birthday" in the morning; a coworker usually bakes a cake for the occasion. Recently, as I walked through a staff room in the early morning, I saw that a supervisor had placed a cake on one of

her nurse's desks. The cake was inscribed with the nurse's name, which indicated forethought and concern for the nurse as a person.

12. Social interaction on the part of staff that conveys the feeling of belonging.

13. Opportunity to serve as a preceptor for students.

Retention of Supervisors and Administrators

Although we usually discuss retention in the context of visiting staff, we must not forget the supervisory and administrative levels. Many times individuals are promoted because of seniority or educational attainment rather than because of their leadership ability, personality, or interest. There are times when administrators must choose supervisors from a group of applicants (or one) who are ill-prepared in the responsibility of a supervisory role.

We can enhance supervisory skills through continuing education, formal education, and in-service programs, but most of us do not have the time for extensive training. We need seasoned leaders NOW! Therefore, I believe it is most important to develop our qualified, existing staff for promotion to higher level jobs.

I am aware of several supervisors and administrators who are thinking of leaving or have left their positions in HHAs during the past year. A brief reference to personal characteristics found in the literature may be helpful in providing a rationale for these defections.

Years ago, I read the following definition:

> "The Public Health Nurse Supervisor must be a virtual wonder-woman (or man). The supervisor must have the enthusiasm of a college freshman, the patience of a saint, the determination of a taxi driver, and the tireless energy of a bill collector."

Have we taken these characteristics into consideration when we hire or promote a nurse to the supervisory level?

The National League for Nursing (NLN) Accreditation Manual (1986, p. 17) indicates that the director should implement board policy; manage the agency; do community assessment; plan, develop, administer, and evaluate agency programs; oversee financial management; and work with other organizations to improve the health of the community.

The basic attributes desired in an administrator are listed in Characteristics of the Home Health Agency Administrator (NLN, 1977, p. 3). Included are such personal characteristics as: exhibits a strong commitment and abundant energy for the task;

has "that something extra" required to achieve goals; shows emotional stability; possesses the ability to operate under pressure; and shows initiative, enthusiasm, pragmatism, and creativity.

At a time when there is a nursing shortage, have we reviewed these characteristics with our administrative applicants so there are no surprises the first week in a new position?

At the staff and supervisory level, there are additional personal goals that must be addressed: What is the applicant's goal for this job? In what timeframe? Here is an example. If the new staff nurse comes with previous years of CHN and is seeking a supervisory level position, she must know that there are a limited number of these positions available and that the turnover is low. The same is true for administrative jobs.

SUMMARY

Alfano (1988) stated in her January/February editorial that we must understand that bonding with one's coworkers keeps most people in a setting over and above money and power. She points out that recruiting will be a wasted effort unless staff members get their act together and start welcoming new staff members instead of shutting them out.

The features of CHN that were attractive to applicants in the past are not necessarily the ones that draw now. The autonomy, relationship with physicians, weekend and holiday rotation, working hours, and teaching opportunities may be offset by the increased acuity level of patients, increased paperwork and documentation requirements, decreased satisfaction because of patients' shorter stays, and restrictive reimbursement policies.

In 1988, the important features for staff, supervisors, and administrators are job satisfaction, salary, the opportunity for participation in policy and procedure development, a sense of belonging, recognition of personal worth, and the opportunity to attain personal and professional goals.

At the agency level, these are all related to the retention process -- the mission statement; philosophy; emphasis on quality care; and financial, productivity, and documentation issues. Administrators must manage the agency in a cost-effective manner in order to balance the budget while ever mindful of the many financial and nonfinancial forms of recognition that contribute to the staff satisfaction that results in longevity. Administrative support and encouragement are essential ingredients of the retention process in an HHA.

But all of these goals must be accomplished in 1988 when cost caps and financial cutbacks are a reality. One HHA administrator said, "Having an adequate salary scale continues to be a real problem for a nonprofit agency. This is made more difficult by constantly changing third-party reimbursement and funding policies and legislation both for home health and public health programs." These issues are a consideration for all administrators as we seek to continue to provide quality home health care services and to retain qualified professional staff in a cost containment era.

I also believe that administrators must be aware of those changing job characteristics of community health nursing that attract or deter nurses from this setting.

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RESPONSE TO RETENTION STRATEGIES IN NURSING PRACTICE PANEL

Respondent: Rose Hauer, R.N., M.A.
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Economics is one of the most important issues we have to deal with in retaining nurses because the health care system is economically driven. The nursing shortage is not really a nursing problem because we have so little to say in terms of institutional costs. As Ed Halloran pointed out, the nursing budget represents only a fraction of the total institutional budget. I believe that until we cost out nursing services we will never be in control of anything that has to do with the budget. Also, our vice presidents for nursing have to be on the same organizational level as administrators in other areas. They must know what is going on in an institution in order to have adequate control over the nursing environment and how a nursing department is staffed.

Donna Diers mentioned that the medical-surgical units have the most serious problems with recruitment. I agree with her completely because most specialty areas require young nurses to have experience in medical-surgical nursing before moving into specialty practice. Also, the diagnosis related group (DRG) approach has taken a toll on nursing units by changing the patient mix so that more patients are sicker than in the past with shorter lengths of stay. Today's medical-surgical units are really "mini" intensive care units (ICUs) but are staffed with our most inexperienced nurses. Also, the staffing ratios are much greater than the traditional 1:2 found in ICUs.

Current regulatory systems, utilization review mechanisms, and liability concerns have increased the amount of paperwork nurses are required to do. Several hospitals in New York did a study of how much paperwork a nurse has to attend to in any 7 1/2-hour shift. They found a minimum of 3 1/2 hours was devoted to paperwork. Nurses become very frustrated with the amount of paperwork that takes them away from the bedside. It is time to see if we can develop computer systems to handle some of this documentation and free the nurse to work with patients.

Curricula in schools of nursing have not kept up with the changes in the health care delivery systems. We need to adapt the courses so that the models taught in the educational system are the same models required in practice. Institutional nursing today requires students to be prepared to practice in a primary nursing or case management model and to establish collaborative relationships with physicians. Too many new graduates quickly become frustrated because the clinical experiences and theory that they had as students did not adequately prepare them for the realities of practice.

We have to realistically look at the issues confronting nursing education and nursing practice and deal with them effectively. This nursing shortage is different from those in the past and will be solved with or without the involvement of nurses. It is time for nursing to assert its leadership and determine what we can do to get some control of the economics of the health care delivery system.

RESPONSE TO RETENTION STRATEGIES IN NURSING PRACTICE PANEL

Respondent: Carolyn Williams, R.N., Ed.D., F.A.A.N.
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The Chinese have a greeting for special people, "May you live in interesting times." Indeed, anyone who is involved in the health care system today is living in interesting times. And, if a person is a nurse, he or she is truly living in interesting times.

It is fortunate that at this workshop we have been addressing the nursing shortage as a problem that exists within a much broader context. For this reason, we need to look for short-term remedies while we also maintain a focus on the longer term perspectives. These perspectives also require us to address realistic strategies for invigorating and changing the health care system to become more responsive to the present and future needs of the population.

There are four major problem areas that I believe we need to address. They are:

1. Practice environments are not appropriately structured to allow or support the provision of professional nursing services.

2. Professional nurses have not been treated as professionals nor have they been supported in their professionalism.

3. The transition from the student role to beginning practitioner and the transition from one type of professional role to another have not been dealt with adequately.

4. Our basic educational programs are not structured to appropriately prepare students for the realities of professional practice.

These problems suggest that we need to restructure our educational and nursing service policies and environments to provide for the appropriate career development of professional nurses and for the development and utilization of our knowledge base. Efforts to restructure these areas will have to be carried out in an atmosphere of cost containment. This may mean we will have to make some tradeoffs to ensure that all consumers continue to have access to care. For example, nursing salaries need to be raised but only to the extent that the quality of patient care and the availability of needed services are not jeopardized. There are many viable arrangements that nursing education and nursing service can work out to help deal with these problems. We need to focus much more attention on how these groups can develop enterprises that promote appropriate career development for nurses, allow us to continue to improve the knowledge base for nursing practice and the systems that will foster the utilization of that knowledge, and facilitate changes in the broader system that will make a real difference in our Nation's health care.

We need to build workable models that will structure collaboration between nursing education and nursing service. The three pioneers in the unification models, Rush University, Case Western Reserve University, and the University of Rochester, are represented at this workshop. Each has forged its own unique model. We can all profit from their experiences as we attempt to create models that will work in our own settings. There are many different kinds of arrangements that can be made to improve the environment for teaching as well as create a more viable and stimulating practice environment.

When we come together to formulate recommendations we need to consider ways to fund and support these collaborative models. In addition to Federal funds we should consider other public and private sources, including the use of hospital revenues. Ed Halloran's comments on the appropriateness of nursing service assuming partial responsibility to support nursing education bring up a refreshing and viable option.

While it is trendy to talk about faculty practice, I do believe this is an important model for positive change in our respective environments. Students who work with faculty who are actively engaged in practice receive a much more realistic education. Also, as faculty become more involved in practice they become more realistic about practice requirements and begin to question and modify some of our traditional educational practices.

Major changes are occurring in the economics of health care delivery. Nursing is affected by these changes and must become more concerned with economic factors. Those of us in State schools have begun to recognize that State dollars are not available to support all of the activities we believe are important. Institutions are becoming more intrapreneurial by looking for enterprising ways to generate additional income.

Linkages between nursing education and nursing service show great promise in helping each of us meet our respective needs by pooling economic and other resources. I would much rather pursue cooperative endeavors as opposed to competitive ones. Cooperative endeavors help nursing service retain nurses by assisting them in developing to their fullest potential while schools profit by receiving additional support. We are just beginning to tap the many ways that we can work effectively together.

SUMMARY OF DISCUSSION AFTER RETENTION STRATEGIES IN NURSING PRACTICE PANEL

Discussion focused on the need to gain control of the nursing budget by costing out nursing services. One example cited was St. Mary's Hospital and Health Center, Tucson, AZ, where nursing costs are unbundled. The nursing budget is determined by charging for each hour of patient care. Of the revenue generated, 82 percent represents direct hands-on care and the remainder is used to cover the indirect expenses in nursing (education, some supplies, nursing administration, and other costs). Nursing service generates approximately $26.5 million per year with the actual expense in nursing being $25 million. The remaining $1.5 million is nursing's donation to the profit of the institution. The indirect costs in the hospital budget are billed as part of room and board.

RECOMMENDATIONS

These workshop recommendations acknowledge that both short- and long-range strategies are needed to ensure an adequate supply of nurses in the immediate and distant future. The participants unanimously agreed that current problems in the system of health care delivery directly influence the nursing shortage dilemma. These problems need to be vigorously addressed promptly if quality health care is to be ensured for the American people.

Another major premise that underlies these recommendations is the realization that public funding alone for strategies and projects is neither feasible nor desirable. While some projects clearly require the allocation of public monies, it is recommended for others that priority should be given to soliciting a combination of public and private financial support to provide a foundation on which to build a self-sustaining effort.

1. Establish a coordinated public relations campaign to positively change the image of nursing practice. Because a discrepancy exists between the reality of the practice of nursing and the image often portrayed to the public, a coordinated, multigroup strategy on the local, regional, and national levels should be devised to mount a plan to improve the image of the profession. The campaign should emphasize the rewards of clinical nursing practice and stress the many career opportunities that exist for professional nurses. Nursing is for creative, skillful people from all types of backgrounds.

   Representatives of the nursing profession should work closely with executives in television and other media to promote a positive presentation of nurses. Public service announcements featuring nurses and exciting aspects of nursing should be developed to promote the profession. Responses should be made promptly and vigorously to counter negative images of nurses and nursing.

   The image campaign should also build on the image improvement work of the National Commission on Nursing Implementation Project (NCNIP).

   In general, the image campaign should be designed as a long-term one with the understanding that a substantial amount of money should be allocated to this effort.

2. Provide support for demonstration projects that examine the long-term effects of innovative recruitment programs to increase the supply of nurses. Nursing education programs that use innovative marketing strategies to target and reach traditional and nontraditional applicant pools should be documented and replicated. College graduates, minorities, those seeking a second career, and men are important

targets. Nursing career information should also reach elementary and junior high school students as well as high school students. Families, science teachers, guidance counselors, and others who directly influence student career choices should be involved. Regional and State nurse career centers should be established and supported.

3. Provide support for demonstration projects designed to implement professional practice models for institutionally based nursing practice. Nursing care delivery systems require restructuring to allow nurses more control over the work environment and its resources while also assuring that the health care needs of patients and families are safely met. Projects should focus on demonstrating models of practice that retain and enhance nursing standards of quality care. Different models of practice should be explored and evaluated. Successful models that incorporate elements of case management, decentralized management authority, and rewards for professional practice and growth should be replicated and expanded. Also, projects that document nursing costs by nursing services or develop technological support systems, such as computerized nursing information systems, to extend the effectiveness of the current work force should be encouraged. Models that use nonnurses as substitutes for registered nurses (RNs) should be carefully evaluated before implementation. Projects that identify and maximize utilization of nursing resources within an agency should also be encouraged. It should also be acknowledged that changes in work force models can be agency and geography specific.

4. Establish mechanisms to provide direct payment to nurses for health care services provided by nurses. Recruitment and retention efforts are negatively affected by existing reimbursement policies that fail to acknowledge the professional nurse as the primary care provider to patients with accountability to them across the continuum of care. The group recommended that the Tri-Council for Nursing, composed of the American Nurses' Association, the National League for Nursing, the American Association of Colleges of Nursing, and the American Organization of Nurse Executives, be requested to develop strategies to accomplish this goal of direct payment.

5. Continue to provide direct support to nursing education programs that establish innovative curricula that relate directly to changes in health care and nursing delivery systems. Educational programs should enter into formal collaborative arrangements with service institutions that permit movement of personnel across settings and that demonstrate the development of affordable and effective career development pathways for clinical nurse faculty and nurses in practice. Educational programs must also demonstrate the ability to solicit and receive program

funding from alumni and other private and corporate groups as well as from public funds. Jointly sponsored programs of nursing research and demonstration projects in education and practice are also encouraged. Examples of specific strategies include work study programs, nurse internships, faculty practice models, use of clinical preceptors, and competency-based curricula that remove many of the barriers for RNs wishing to pursue academic degrees. The profession should conduct education research to identify the most sound and efficient ways to prepare nurses for advanced and specialty practice.

6. Provide support for the initial and continued preparation of nurse executives in hospitals and other practice settings. Encourage the development of educational programs based on a strong clinical nursing major that prepares and enhances the ability of nurses to assume executive positions in the health care delivery system. While the curricula of these programs should have the capability to be individualized, they should also include a substantial foundation in business management, finance, decision science, and policy formulation.

APPENDIXES

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National Invitational Workshop on the Nursing Shortage:
Strategies for Nursing Practice and Education
February 22-24, 1988
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National Invitational Workshop on the Nursing Shortage:
Strategies for Nursing Practice and Education
February 22 - 24, 1988

GROUP A (EAST ROOM)	GROUP B (WEST ROOM)	GROUP C (BALLROOM)
Marian Pettengill - Leader	Malinda Mitchell - Leader	Patricia Moritz - Leader
Kathleen Andreoli	Anne T. Avallone	Jean Caron
Judith Baigis-Smith	Joyce Clifford	Vivien DeBack
Jo Eleanor Elliott	Phyllis Ethridge	Anthony Disser
Maryann Fralic	Lillian Gibbons	Vernice Ferguson
Enid Goldberg	Edward Halloran	Mary Germain
Marilyn Harris	Jeanne Kearns	Hurdis Griffith
Rose Hauer	Dorothy Kleffel	Gerry Hansen
Sadako Holmes	Cathy Michaels	Nancy Higgerson
Marlene Kramer	Ada Sue Hinshaw	Carolyn Williams
Ethel Mitty	Evelyn Moses	Lucille Joel
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Sheila Ryan	Sylvia Rhodes	Dorothy Powell
Madeline Turkeltaub	Audrey Spector	Susan Sherman
Roberta Williams	Margretta Styles	Henrietta Villaescusa

AGENDA
NATIONAL INVITATIONAL WORKSHOP ON THE NURSING SHORTAGE: STRATEGIES FOR NURSING PRACTICE AND EDUCATION

Vista International Hotel
Washington, DC
February 22-24, 1988

MONDAY, FEBRUARY 22, 1988

5:30 p.m. - 6:30 p.m.	REGISTRATION AND CASH BAR
6:30 p.m. - 7:30 p.m.	DINNER
7:30 p.m. - 8:30 p.m.	OPENING REMARKS AND INTRODUCTION
	Jo Eleanor Elliott Director, Division of Nursing
	KEYNOTE ADDRESS
	Donna Diers

TUESDAY, FEBRUARY 23, 1988

8:00 a.m. - 8:30 a.m.	CONTINENTAL BREAKFAST
8:30 a.m. - 1:00 p.m.	Moderator: Jo Eleanor Elliott
8:30 a.m. - 9:30 a.m.	OVERVIEW OF NURSE MANPOWER AND RELATED ISSUES
	Current Data on Nurse Supply
	Evelyn Moses
	Update on the National Commission on Nursing Implementation Project
	Vivien DeBack
	Question and Answer Period
9:30 a.m. - 1:00 p.m.	RECRUITMENT ISSUES AND STRATEGIES
9:30 a.m. - 11:00 a.m.	Recruitment Strategies in Nursing Education Panel
	Presenters: Madeline Turkeltaub
	Kathleen G. Andreoli
	Respondents: Anthony Disser

	Vernice D. Ferguson
	Question and Answer Period
11:00 a.m. - 11:30 a.m.	BREAK
11:30 a.m. - 11:45 a.m.	Greetings
	Don M. Newman, Under Secretary Department of Health and Human Services
11:45 a.m. - 1:00 p.m.	Recruitment Strategies in Nursing Practice Panel
	Presenters: Joyce C. Clifford
	Ethel Mitty
	Respondents: Susan Sherman
	Sheila Ryan
	Question and Answer Period
1:00 p.m. - 2:30 p.m.	LUNCH/DUTCH TREAT
2:30 p.m. - 4:00 p.m	RETENTION ISSUES AND STRATEGIES
	Moderator: Mary S. Hill Nursing Education Branch, Division of Nursing, BHPr
2:30 p.m. - 4:00 p.m.	Retention Strategies in Nursing Education Panel
	Presenters: Gerry Hansen
	Lucille Joel
	Respondents: Maryann Fralic
	Dorothy Kleffel
	Question and Answer Period
4:00 p.m. - 4:30 p.m.	BREAK
4:30 p.m. - 6:00 p.m.	Retention Strategies in Nursing Practice Panel
	Presenters: Edward J. Halloran

Marilyn D. Harris

Respondents:
Rose Hauer

Carolyn Williams

Question and Answer Period

WEDNESDAY, FEBRUARY 24, 1988

8:00 a.m. - 8:30 a.m.	CONTINENTAL BREAKFAST
8:30 a.m. - 10:30 a.m.	GROUP WORK - PREPARATION OF RECOMMENDATIONS
	Group A Facilitator: Marion Pettengill
	Group B Facilitator: Malinda Mitchell
	Group C Facilitator: Patricia Moritz
10:30 a.m. - 11:00 a.m.	BREAK
11:00 a.m. - 12:00 noon	GROUP REPORTS
	Conference Summary
12:00 noon - 12:30 p.m.	CLOSING REMARKS

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